Chambers Plan
Employee Benefits

JG35-CH

# Travel Health Claim

CLAIMS PROCESSED BY DESJARDINS INSURANCE

**Please print your Firm & Certificate #**

| Firm # | Certificate # |
|---|---|
| | |

First Name _____ Last Name _____

Employee's Full Mailing Address _____ Date of Birth (YYYY/MM/DD) _____

Patient's Name _____ Relationship to Employee _____ Date of Birth (YYYY/MM/DD) _____

If the patient is a dependent child, the child: ❑ has a physical or mental disability

❑ is a student (school's name and location) _____

_____ Dates of Studies (YYYY/MM/DD) _____

**Departed from Home Province (YYYY/MM/DD)** _____ **Originally Scheduled Return (YYYY/MM/DD)** _____ **First Treatment (YYYY/MM/DD)** _____

Are you or your dependents eligible for benefits under any other insurance plan? ❑ Yes ❑ No

If "Yes", family member insured _____

Name and address of insuring company _____ Policy No. _____

**This claim is the result of ❑ a sudden illness (go to next section) ❑ an accident (complete the rest of this section)**

Type of Accident _____

Date of Accident _____

Details of Accident _____

_____

Location of Accident _____

Name and Address of Lawyer Representing You With Respect to the Accident

_____

_____

Why did you need medical attention? What was the nature of the illness or injury? _____

_____

Attending Physician

Name _____

Address _____

_____

Family Physician at Home

Name _____

Address _____

_____

Were you hospitalized? ❑ No ❑ Yes

If "No," who provided treatment?

Name _____

Address _____

If "Yes," where were you hospitalized?

Hospital Name _____

Address _____

_____

## STATEMENT OF EXPENSES (ATTACH RECEIPTS)

| | Organization Name on Billing | Date of Service | Amount/Currency |
|---|---|---|---|
| Hospital | | | |
| Ambulance | | | |
| Prescription Drugs | | | |
| Other | | | |
| | | | |

**TOTAL** Please pay: ❑ the provider or ❑ the individual _____

## ALL DOCUMENTS MUST BE TRANSLATED TO ENGLISH/FRENCH PRIOR TO SUBMISSION.

All the information I have provided on the form is accurate and complete, to the best of my knowledge, and I certify that the enclosed receipts represent a claim for services rendered to me and/or eligible members of my family. If this claim is being made on behalf of my spouse and/or dependents, I am authorized to disclose information about them for the purposes of assessing and paying a benefit, if any. I understand that the fees listed in this claim may not be covered or may exceed my group insurance benefits. I understand that I am financially responsible for the entire cost of services received and that this claim is for reimbursement of eligible charges.

I authorize Chambers of Commerce Group Insurance Plan to collect, use, maintain and disclose personal information relevant to this claim for the purposes of benefit plan administration, assessment, investigation, claim management, underwriting and for determining Plan eligibility. The non-exhaustive list of sources from which information can be collected includes medical and health professionals, facilities or providers, insurance companies, or other organizations/persons. This authorization is also valid for the collection, use and communication of personal information concerning my dependents, insofar as applicable to the administration of benefits under this plan. Any copy of this authorization shall be as valid as the original.

Employee's or Legal Representative's Signature _____

Date _____ Phone (_____) _____ Email _____

**THIS PLAN DOES NOT COVER ANY CHARGES FOR THE COMPLETION OF A FORM OR TRANSLATION COSTS.**

## Exclusions and Limitations

Extended Health benefits are not payable under any of the following circumstances:

- experimental services, treatments or supplies, or charges for services which are not medically necessary;
- drugs, injections or products for the treatment of obesity;
- travel vaccines, patent medicines, general health exams and physicians' fees;
- services or treatment provided by anyone related by blood or marriage or living in the insured's residence (this might come up, for example, if an insured lives with a dentist or pharmacist); or services, treatment or supplies provided to the employee by the employer;
- expenses as a result of intentionally self-inflicted injuries, while sane or insane;
- cosmetic treatment expenses, except as a result of an accidental injury;
- treatment for injuries sustained while committing or attempting to commit a criminal offence;
- expenses for which payment is provided under any Workers' Compensation Act or similar legislation, government plan or any other plan;
- injuries caused directly or indirectly by insurrection and war, or participation in a riot or civil disorder;
- personal comfort items and erectile dysfunction drugs/items;
- forgotten or lost medication refills;
- services, treatment or supplies which the individual received without charge, or amounts in excess of reasonable and customary charges for the least expensive treatment that is medically appropriate;
- travel time, broken appointments, transportation costs, telephone or other indirect consultations;
- expenses related to temporomandibular joint dysfunction;
- expenses related to implants;
- elective treatments and services not listed in eligible expenses;
- out of province referrals.

Please refer to your booklet for complete details on exclusions and limitations.

**For immediate assistance in a medical emergency outside your province of residence, contact *Voyage Assistance*:**
**Inside Canada or the US, call 1 800 465.6390 | Outside Canada or the US, call collect 1 514 875.9170**
**They are open 24 hours a day, seven days a week to assist with your emergency.**

## Identifying Yourself

*Voyage Assistance* needs the following information to identify you as a plan participant.

Group: **Chambers of Commerce Group Insurance Plan**

Insured's Name _____

Firm and Certificate # _____

Effective Date of Coverage _____

The above information is found in the *my-benefits* app under *Benefits*. We recommend you carry a printout of the Benefits card with you when you travel.

**Please contact our office for inquiries about your coverage.**

**Chambers of Commerce Group Insurance Plan®**
**1051 King Edward Street, Winnipeg, MB R3H 0R4**
**1 800 665.3365 (In Winnipeg 204.774.6677)**
**www.chamberplan.ca**

Chambers Plan
Employee Benefits