LIONS GATE
UNDERWRITING

Claim No.

c/o INTERNATIONAL PROGRAMS GROUP (IPG)
Suite 2401, 120 Adelaide St. West., Toronto, ON, Canada M5H 1T1

North America Toll free: 1 866 410 1226
Email: LionsGateUW@scm.ca

STATEMENT OF CLAIM FOR MEDICAL EXPENSES

IMPORTANT INSTRUCTIONS

- **Please ensure this Statement of Claim for Medical Expenses form is fully completed and returned to INTERNATIONAL PROGRAMS GROUP within 30 days of the date of medical treatment.**

- Please complete 1) this claim form, 2) the Authorization to Physicians, Hospitals and Other Medical Providers, 3) the appropriate provincial Schedule (see below). The Medical Report is to be completed by the claimant's Family Physician only if requested.
- Attach all ORIGINAL invoices and receipts for medical services, if any have been provided to you, and indicate whether or not they have been paid, indicating currency and amount(s) paid.
- Attach copies of all physician, emergency room and/or hospital reports or summaries, if available.

TO BE FULLY COMPLETED BY CLAIMANT or Parent or Guardian, if a minor.

Claimant's Name

Name of Insurance Broker:

Broker No:

Primary Policyholder's Name & Address

Policy No:

Departure date D/ M/ Y/

Return date D/ M/ Y/

Insurance purchase date D/ M/ Y/

Sex M/F Birth Date D/ M/ Y/

Phone Res. ( )_____ Bus ( )_____ Fax ( )_____

Family Physician full name, address _____

plus list all physicians seen in past six (6) months prior to travel _____

_____

Sickness commenced/injury occurred on D/ M/ Y/ First treated on D/ M/ Y/ by Dr. _____

In (Town)_____ (Country)_____ Diagnosis: _____

Were you hospitalized as an in-patient? If NO, initial _____

If YES, confined from D/ M/ Y/ to D/ M/ Y/ Name of Hospital _____

Describe your sickness, or the accident and your injuries. (For death, give date, cause and describe sickness/injury that resulted in death.)

_____

_____

List all trips taken in the 12 months immediately preceding this trip (incl. departure date, return date and destination): If NONE, initial _____

_____

_____

Name of Employer _____ Phone ( )_____

Spouse's Employer_____ Phone ( )_____

Are you covered under any other private or group medical/dental insurance plans (own, spouse's or guardian's)? If NO, initial _____

If YES, circle – Employee Benefit, Retirement Benefit, Travel Insurance or Credit Card Plan and complete details below:

Insurer _____ Have you submitted claim to them?

Address _____ If YES, submitted on D/ M/ Y/

_____ If NO, initial _____ and submit to INTERNATIONAL PROGRAMS GROUP

Phone ( ) Group No. Policy No. ID NO.

Note – Claimant to complete**: 1) Authorization to Physicians, Hospitals . Other Medical Providers . Special Authorization;**
2) BC Residents – Schedule A&B ; ON. Residents – Authorization and Release;
MB Statement of Agreement & Understanding
All Residents except BC and ON. & MB – Assignment of Payment and Release.

Claimant to complete:

Authorization to Physicians & Hospitals
& Other Medical Providers
and
Special Authorization for Exchange of Information

1. I, the undersigned, hereby authorize any hospital, physician, or medical facility to release my medical information to the Insurer's authorized representatives, including INTERNATIONAL PROGRAMS GROUP and/or its authorized representatives. I further consent to the disclosure of this information by INTERNATIONAL PROGRAMS GROUP to other sources as may be required to obtain benefits from other sources.

2. I, the undersigned, hereby assign to INTERNATIONAL PROGRAMS GROUP any benefits obtainable from other sources for covered losses under this policy. I also direct these sources to forward payment to INTERNATIONAL PROGRAMS GROUP with regard to these losses.

3. I warrant that neither I nor any Insured Person for whom coverage applies under this policy has any additional coverage through any other insurer (other than that listed above).

4. I understand that my insurance shall be void if, whether before or after the loss, any person has concealed or misrepresented any fact or circumstance concerning this claim.

5. I further authorize the full exchange of information, including medical information, amongst the Insurer and/or its authorized representatives, agents and/or consultants.

Assignment effective from (travel dates): ____/____/_____ to ____/____/_____
MM DD YYYY MM DD YYYY

_____
Claimant's or Authorized Person's Signature

Date: _____

NOTICE OF PRIVACY & CONFIDENTIALITY: Lions Gate Underwriting Agency and its affiliates will collect, use and disclose the personal information which you give for the purpose of providing you with insurance services. To protect its confidentiality, access to this information will be restricted to those employees, mandataries, administrators or agents of Lions Gate Underwriting Agency and their authorized representatives who are responsible for administration of services, underwriting, and for the processing, facilitating and investigation of claims. When necessary, this information may be shared with others such as, but not limited to, medical facilities, Insurers, organizations and any other person you authorize or that is authorized by law. This acknowledges that information may be transmitted by facsimile (fax), e-mail, postal service, courier service or telephone, and we cannot guarantee the security or privacy of the information that is transmitted through these channels.
Lions Gate Underwriting is a trading name of BMS Canada Risk Services Ltd.