AIG Insurance Company Of Canada
145 Wellington Street West
Toronto, ON M5J 1H8
416-596-4005 | 1-877-317-8060
ahclaimscan@aig.com | www.aig.com

OUT OF PROVINCE HOSPITAL/MEDICAL INSURANCE CLAIM FORM

PLEASE ATTACH ALL ORIGINAL RECEIPTS AND PROOF OF TRAVEL.

POLICY NO:_____ COMPANY NAME _____CERTIFICATE #(if applicable)____-_____-____

PLEASE PRINT:

Member's Surname:	Member's Given Name:
Patient's Name:	Relationship to Member:
Street & No.:	Email address:
Apt./Unit No.:	Telephone No.: ( )
City/Town:	Province: Postal Code:
Patient's Date of Birth: M _____ D_____ Y _____	Patient's Health Card No. and Verification Code:

Total Amount of this claim : $_____

OUT OF PROVINCE TEMPORARY ADDRESS:

1. Departure Date of planned trip: Return Date Destination:
2. Mode of Transportation: Reason for Trip:
3. Name and Address of Family Physician:
4. Name and Address of first Physician consulted:
5. Date of initial onset of illness or injury: Date of Previous Occurrence or Treatment:
6. Diagnosis:
7. If hospitalized, advise date of admission: _____ Discharge Date: _____

   Name of Hospital:_____

   Address:_____

8. If illness, has the patient had this or similar illness before: NO ( ) YES ( )

If yes, give dates, name/address of physician: _____

9. Was the current treatment due to an emergency? ( )Yes ( )No

10. Was the patient advised to seek treatment for this condition in a place other than their normal province of residence
( )Yes ( )No

If Yes, please explain_____

11. Name and address of Employer:_____

Employer Phone Number:_____

12. Do you carry any other excess Hospital/Medical or Travel Insurance ( ) Yes ( ) No
If Yes, Name of Insurance Company _____

Address_____

Policy/Certificate/ID number_____ Telephone number _____

13. Do you have a premium credit card (GOLD CARD) which provides out-of-province medical? ( ) Yes ( ) No

If Yes, Name of Insurance Company _____

Address _____

Policy/Certificate/ID number_____ Telephone number _____

14. If injuries are the result of an automobile accident, please provide Name of Insurance Company _____

Address _____ Telephone number _____

Policy Number:_____ Claim Number: _____

Name/Address of Insured, if other than yourself_____

PERSONAL INFORMATION NOTICE: I understand that the information provided by me on this claim form and otherwise in respect of my claim, is required by AIG Insurance Company of Canada, its reinsurers and authorized administrators (the "Insurer") to assess my entitlement to benefits, including but not limited to determining if coverage is in effect, investigating the applicability of exclusions and co-ordinating coverage with other insurers. For these purposes, the Insurer will also consult its existing insurance files about me, collect additional information about and from me, and where required, collect information from and exchange information with, third parties.

CERTIFICATION: The statements I provide in completing this claim form and otherwise in respect of my claims are true and complete to the best of my knowledge and belief. In the event of a false or misleading statement in the making of this claim, coverage can be cancelled, payment of benefits denied and past claims payments recovered. I agree to refund to the Insurer, the amount of any payments made in the event that such amounts should not have been paid in respect of my claim.

AUTHORIZATION: I authorize, for a period of not less than twelve and not more than twenty-four months from the date hereof, any physician, practitioner, health care provider, hospital, health care institution, medical organization, clinic and any other medical or medically related facility, any insurance company or reinsurance company, workers compensation board or similar plan or organization, benefit plan administrator, federal, territorial or provincial government department, or any other corporation or organization, institution or association (including obtaining information from the group policyholder or my employer) to release and exchange with AIG Insurance Company of Canada, or representatives thereof, all personal health information and benefit payment information about me or any other information or records about me in its possession that is requested while administering my claim.

I agree that a reproduction of this authorization shall be as valid as the original.

Dated: _____ Signed:_____

IN ORDER FOR YOUR CLAIM TO BE PROCESSED, THE FOLLOWING MUST BE SIGNED AND DATED.

I agree to reimburse to AIG Insurance Company of Canada the amounts reimbursed to me on behalf of my provincial health insurance plan, or any other insurance plan who has made payment towards costs of services that have been paid, on my behalf, by AIG Insurance Company of Canada. All refunds will be made payable to AIG Insurance Company of Canada by cheque or money order and shall be remitted within 30 days of receipt.

Dated_____ Signed_____

PLEASE REMEMBER TO ATTACH ALL ORIGINAL RECEIPTS AND PROOF OF TRAVEL.