

**IMPORTANT NOTICE**


A duly completed and signed claim form is necessary even if you haven't made any payments. Your public health insurance plan covers some of the fees for medical care received during your trip. CanAssistance reimburses these fees in full, but must submit them to your provincial health insurance plan.


In accordance to the terms of your contract, by signing the form you authorize CanAssistance to:

- Access your personal and medical information required to adjudicate your claim
- Pay eligible expenses to service providers directly


**Failure to return the duly completed form entitles CanAssistance to ask you to refund the fees paid on your behalf.**

**Filing a claim**

-  Complete the claim form(s) and sign where designated with an X.
- Each person who received healthcare services must complete a claim form.
  - The form must be signed by the beneficiary (person who received healthcare services). If the claim involves a minor, the policyholder must sign the form.

-  Attach all the following documents:
- Original itemized bills for all healthcare services received, the diagnosis and treatment must appear clearly .
  - Original prescription drug receipts showing the name of the drug, the dosage and the price.
  - Proof of payment for all expenses claimed, such as a credit card statement or proof of a deposited cheque showing the currency in which the service was paid. In the absence of a bank or credit card statement, a receipt may be accepted.
  - Proof of your departure and return dates, such as a plane ticket, a stamped copy of your passport, a bank or credit card statement showing purchases made in Canada just before your departure date and immediately after your return.
  - Any other relevant document(s), such as medical reports, lab results, etc.

 We recommend you keep a copy of your claim documents for record-keeping purposes, as they will not be returned.

 Send the duly completed forms and all other required scanned documents online via our secure website:

**[canassistance.com/en/policyholder/depot](https://canassistance.com/en/policyholder/depot)**

We reserve the right to request the original documents up to one year from the date of submission of your claim.  
Or send the forms and original claims documents by mail to:

Quebec :  
**CanAssistance**  
Travel Claims Department  
1981, McGill College Avenue, Suite 400  
Montreal, Quebec H3A 2W9

Ontario :  
**CanAssistance**  
Travel Claims Department  
P.O. Box 4439, Station A  
Toronto (Ontario) M5W 3Z4

**Additional Information**

Your claim will be reviewed as quickly as possible once we've received the required documents. The following situations may increase the time it takes us to process your claim:

- An incomplete claim form or missing document
- Delayed or missing detailed invoice
- Delayed or missing medical information

Eligible expenses are reimbursed in Canadian funds by cheque made out to the policyholder. If you're covered by more than one travel insurance policy, indicate this on your claim form. We will work with your other insurer to coordinate your benefits as needed.

If you receive a bill, please do not make any payments directly to the service provider unless we instruct you to do so. Simply send it to the address above.

Should you have any questions about your claim, please contact us by using the phone number on your insurance card or visit our website at [canassistance.com](https://canassistance.com).

**AVIS IMPORTANT**

Une demande de règlement dûment remplie et signée est essentielle même si vous n'avez rien déboursé. Votre régime public d'assurance santé couvre une partie des frais pour les soins médicaux que vous avez reçus lors de votre voyage. CanAssistance rembourse entièrement ces frais, mais elle doit les soumettre à votre régime provincial d'assurance.

Conformément aux conditions générales du contrat, en signant le formulaire, vous autorisez CanAssistance à :

- accéder à vos renseignements personnels et aux renseignements médicaux pertinents à l'analyse de votre demande de règlement;
- payer directement les fournisseurs de service lorsque les dépenses sont admissibles.

**Tout défaut de retourner le formulaire autorise CanAssistance à vous demander de rembourser les frais qui ont été payés en votre nom.**

**Faire une demande de règlement**

Remplissez la demande de règlement et signez aux endroits désignés par un X.

- Si plusieurs assurés ont reçu des soins médicaux, chaque personne doit remplir un formulaire.
- La demande doit être signée par le bénéficiaire (la personne qui a reçu des services de santé). Si la demande concerne un assuré mineur, elle doit être signée par le titulaire de la police.



Joignez tous les documents suivants:

- Factures originales et détaillées pour tous les services de santé reçus, le diagnostic et le traitement doivent y figurer clairement.
- Reçus originaux pour les médicaments d'ordonnance indiquant le nom du médicament, la posologie et le prix.
- Preuve de paiement pour tous les frais réclamés, tel que la copie d'un relevé de carte de crédit ou une preuve de chèque encaissé indiquant la devise dans laquelle le service a été payé. À défaut de relevé, un reçu de transaction peut être accepté.
- Preuve des dates de votre départ et retour, tel qu'un billet d'avion, de train, une copie du passeport estampillé, un relevé bancaire ou de carte de crédit montrant des achats au Canada juste avant votre départ et immédiatement après votre retour.
- Tout autre document pertinent, tel que rapports médicaux, résultats de laboratoires, etc.



Nous vous recommandons de faire une copie de vos pièces justificatives pour vos dossiers, car ils ne vous seront pas retournés.



Transmettez les formulaires dûment remplis et vos documents numérisés via notre site sécurisé :

**[canassistance.com/fr/assures/depot](https://canassistance.com/fr/assures/depot)**

Nous nous réservons le droit d'exiger les documents originaux jusqu'à un an suivant le dépôt de la réclamation.

Ou envoyez les documents originaux par la poste à :

Québec :  
**CanAssistance**  
Service des règlements d'assurance voyage  
1981, avenue McGill College, bureau 400  
Montréal (Québec) H3A 2W9

Ontario :  
**CanAssistance**  
Service des règlements d'assurance voyage  
C.P. 4439, succursale A  
Toronto (Ontario) M5W 3Z4

**Informations supplémentaires**

Votre réclamation sera analysée dans les meilleurs délais suivant la réception des documents. Toutefois, certains aspects pourraient entraîner des retards dans le traitement de votre réclamation :

- toute demande incomplète ou des documents manquants;
- retard ou difficulté à obtenir une facture détaillée;
- retard ou difficulté à obtenir des renseignements médicaux.

Les dépenses admissibles sont remboursées en devise canadienne par chèque libellé au titulaire de la police. Si vous êtes couvert par plus d'une police d'assurance voyage, indiquez-le sur votre formulaire de réclamation. Nous ferons la coordination des bénéfices avec l'autre assureur au besoin.

Si vous recevez une facture, ne faites aucun paiement directement au fournisseur à moins d'instructions contraires de notre part. Veuillez nous envoyer toutes les factures reçues à l'adresse indiquée ci-dessus.

Si vous avez des questions, vous pouvez communiquer avec nous au numéro d'assistance apparaissant sur votre carte d'assurance ou visitez notre site internet à l'adresse suivante : [canassistance.com](https://canassistance.com).



**IMPORTANT NOTICE**

If your claim is deemed admissible, by default a cheque will be sent to the policyholder. If you prefer to receive the reimbursement in your chequing account through the direct deposit option, please complete this form and attach a sample cheque.

We recommend that you select direct deposit for a number of reasons:

- Avoid the many possible days that come with receiving cheques by mail.
- Access your funds immediately without any holds that may be required by your financial institution.

Online via our secure website:

[canassistance.com/en/policyholder/depot](https://canassistance.com/en/policyholder/depot)

Send all scanned documents and keep originals. We reserve the right to request the original documents up to one year from the date of submission of your claim.

By regular mail :

**CanAssistance, Travel Claims Department  
1981, McGill College Avenue, Suite 400, Montreal, Quebec H3A 2W9**

**Policyholder identification**

Name of the policyholder

Contract or certificate number

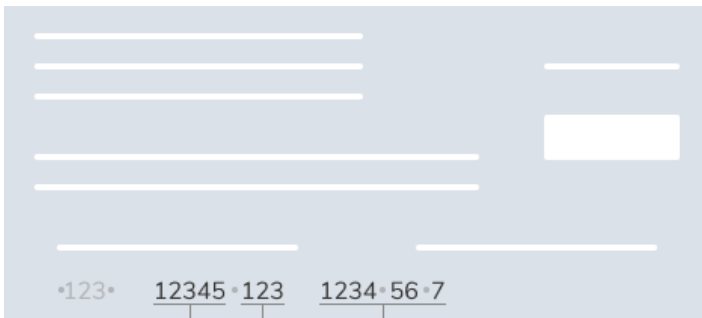
File number

**Bank Account Details (Canadian financial institutions only)**

To avoid payment errors and delays, please attach a sample cheque. A copy can also be obtained through the online banking services of your financial institution.

Scan the document or take a photo of it, making sure all information is legible.

If you are unable to provide a sample check, please carefully complete the sections below.



Branch number \_\_\_\_\_

Institution number \_\_\_\_\_

Account number \_\_\_\_\_

1 - Transit  
(Branch)  
Number

2 - Financial  
Institution  
Number

3 - Account  
Number

I hereby request that my benefits be paid via electronic funds transfer (direct deposit) into the aforementioned account number.

Signature of the policyholder \_\_\_\_\_

Date day / month / year



**OUT-OF-PROVINCE CLAIM**

SECTION A   PATIENT INFORMATION (To Be Completed By Patient or Parent/Guardian) – PLEASE PRINT CLEARLY					
Patient Surname		All Given Names		MCP Number	
Surname at Birth (if different from above)		Date of Birth YYYY MM DD	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Daytime Telephone Number	Email Address
PERMANENT Mailing Address: Street / P.O. Box			City / Town	Province	Postal Code
TEMPORARY Mailing Address: Street / P.O. Box			City / Town	Province / State	Postal / Zip Code
Date of Departure From Home YYYY MM DD	Place Where Treated (Province/Territory)		Date of Arrival YYYY MM DD	Is this a Permanent Move? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Return Home YYYY MM DD
Reason for Absence From Home: <input type="checkbox"/> Vacation <input type="checkbox"/> Business <input type="checkbox"/> Study – Name of Institution _____ <input type="checkbox"/> Other – Specify _____					
<b>DECLARATION</b> I hereby declare, conscientiously believing it to be true and knowing it to have the same effect as if it were made under oath and by virtue of the Canada Evidence Act, that the information given above is correct and that I am a beneficiary of the Newfoundland & Labrador Medical Care Plan.					
Signature of Patient (or parent/guardian, if applicable): _____ Date: _____					
Parent/guardian signature required if patient is less than 16 years of age. If signed by other than patient, please state relationship to patient. _____					
SECTION B   PAYMENT INFORMATION					
Payment should be made to: <input type="checkbox"/> Treating physician <input type="checkbox"/> Patient / contract holder <input type="checkbox"/> Third party – Specify _____					
Address of Third Party (if applicable): Street / P.O. Box			City / Town	Province / State	Postal / Zip Code
SECTION C   PHYSICIAN / TREATMENT INFORMATION (To Be Completed By Physician) - PLEASE PRINT CLEARLY					
Physician Surname		All Given Names		Specialty <input type="checkbox"/> Certified <input type="checkbox"/> Non-Certified	
Street / P.O. Box		City / Town	Province / State	Postal / Zip Code	
Name of Referring Physician		Services Provided In: <input type="checkbox"/> Office <input type="checkbox"/> Home <input type="checkbox"/> Hospital In-Patient <input type="checkbox"/> Hospital Out-Patient			
If <input type="checkbox"/> Anesthetist <input type="checkbox"/> Surgical Assist <input type="checkbox"/> Psychiatrist Provide duration of service: Hours _____ Minutes _____					
IF HOSPITAL SERVICES: Name of Hospital			Admission Date YYYY MM DD	Discharge Date YYYY MM DD	
Street / P.O. Box		City / Town	Province / State	Postal / Zip Code	
Procedure / Treatment	Fee Code	Fee	Date of Service YYYY MM DD	Duration	For Office Use Only
			YYYY MM DD		
			YYYY MM DD		
			YYYY MM DD		
			YYYY MM DD		
			YYYY MM DD		
Diagnosis and Other Remarks					
Claim Involves: <input type="checkbox"/> Workers' Compensation <input type="checkbox"/> Pensionable Disability <input type="checkbox"/> Automobile Accident <input type="checkbox"/> Other Third Party		Physician's Signature		Date	Language of Correspondence <input type="checkbox"/> English <input type="checkbox"/> French

**PLEASE PROVIDE ORIGINAL DOCUMENTATION**

**PRIVACY NOTICE**

Personal health information collected, used, disclosed, and safeguarded is in accordance with the *Personal Health Information Act* (PHIA). If you have any questions about the collection or use of this information please contact our office. The Department of Health and Community Services privacy statement can be found at [www.health.gov.nl.ca/health/PHIA](http://www.health.gov.nl.ca/health/PHIA).