The Great-West Life Assurance Company

STATEMENT OF CLAIM
OUT-OF-COUNTRY EXPENSES

Great-West Life
your Benefits Solutions People

Please complete both sides of this form and mail to Great-West Life, Attention: Out-of-Country Claims Department PO Box 6000 Winnipeg MB R3C 3A5.

When submitting your claim, be sure to attach the required provincial forms available to you by visiting www.greatwestlife.com or by calling our Out-of-Country Claims Department at 1.800.957.9777.

Completion of **these** forms will allow us to pay eligible claims and coordinate payment directly with your provincial health plan or with any other insurance carriers.

GENERAL INFORMATION

Name of Employee _____

Complete Mailing Address _____

_____ Phone Number _____

Employer _____ Plan Number _____ I.D. Number _____

I authorize the release of any information or record(s) requested in respect of this claim to Great-West Life or its agents and certify that the information given herein is true, correct, and complete to the best of my knowledge.

Employee's Signature _____ Date _____

At Great-West Life, we recognize and respect the importance of privacy. Personal information that we collect will be used for the purposes of assessing your claim and administering the group benefits plan. For a copy of our Privacy Guidelines, or if you have questions about our personal information policies and practices (including with respect to service providers), write to Great-West Life's Chief Compliance Officer or refer to www.greatwestlife.com.

I authorize Great-West Life, any healthcare provider, my plan administrator, other insurance or reinsurance companies, administrators of government benefits or other benefits programs, other organizations, or service providers working with Great-West Life, located within or outside Canada, to exchange personal information when necessary for these purposes. I understand that personal information may be subject to disclosure to those authorized under applicable law within or outside Canada. I certify that the information given is true, correct, and complete to the best of my knowledge.

PATIENT INFORMATION

Name of Patient _____ Birthdate _____

Relationship to Employee _____ Purpose for Travelling _____

Date of Departure _____ Scheduled Return Date _____

Actual Return Date _____ Country Visited _____ Currency Used _____

Please provide a brief description of the illness/injury which required treatment outside Canada:

_____

_____

_____

_____

Date of initial onset of symptoms _____ 1st date you received medical attention for these symptoms _____

Prior to leaving Canada, was the patient aware of, or receiving treatment for this condition? ☐ Yes ☐ No

If yes, what was the last treatment date in Canada? _____

I authorize Great-West Life to make payment directly to the providers of the service.

Employee's Signature _____

STATEMENT OF EXPENSES

Total number of invoices/bills included with this claim _____

Please itemize the expenses below. Attach a separate page if additional space is needed.

DATE	PROVIDER	AMOUNT
	TOTAL DOLLAR VALUE OF BILLS SUBMITTED	**$**

STATEMENT OF OTHER INSURANCE

Are you or any other member of your immediate family entitled to travel and/or medical insurance benefits under any other policy, including other group coverage through employment, individual/private travel plans, or credit card plans that will cover a portion of this claim?

☐ **YES** ☐ **NO**

If Yes, please provide the following information:

Type of other Coverage: (group, individual, credit card)		**Name and phone number of Other Carrier:**	
Policy or Plan Number:		**I.D. Number:**	

Have you sent a claim and/or otherwise contacted the other carrier about this claim? ☐ **YES** ☐ **NO**

Please sign the following statement if you have other insurance. This allows us to coordinate the payment of your claim with other insurance carriers. This statement must be signed before any benefits can be paid.

I _____ *hereby authorize Great-West Life and it's agents to*
(signature)

coordinate the payment of benefits with any other insurance carriers which may also have a liability for this claim. I hereby irrevocably direct Great-West Life to make payments, receive payments, and negotiate settlements with providers and other carriers on the patient's behalf.

I further authorize Great-West Life to release and/or receive medical information from providers and other carriers to facilitate the payment and coordination of this claim.

THE Great-West Life ASSURANCE COMPANY

Great-West Life
your Benefits Solutions People

Please complete Schedule A and Schedule B (reverse).
These forms will be returned to the claimant if not fully completed.

IMPORTANT: *Your provincial health plan does not cover out-of-country claims received by them more than 90 days from the date services were rendered. This form must be returned to Great-West Life within 3 weeks prior to this date to allow sufficient time for submission to MSP. Failure to return this form, fully completed on both sides, within the allotted time may result in a denial of benefits from both MSP and Great-West Life.*

Schedule "A"

ASSIGNMENT OF PAYMENT DUE TO INSURED PERSON OR BENEFICIARY UNDER THE MEDICARE PROTECTION ACT OR HOSPITAL INSURANCE ACT.

BETWEEN: _____
(patient name) (of the first part hereinafter referred to the Assignor)

AND: THE GREAT-WEST LIFE ASSURANCE COMPANY
(of the second part hereinafter referred to as the Assignee)

AND: HER MAJESTY THE QUEEN IN THE RIGHT OF THE PROVINCE OF BRITISH COLUMBIA AS REPRESENTED BY THE MINISTER OF HEALTH
(Hereinafter referred to as the Minister)

WHEREAS the Assignor is a person eligible for insured services or benefits or both under the Province of British Columbia's Medicare Protection Act or Hospital Insurance Act or both, and as such may receive payment for the above services from the Minister.

And WHEREAS the Assignor is under a covenant of obligation under a contract with the Assignee to remit to the Assignee all such payments received for medical services from the Minister.

NOW WITNESSETH THAT in consideration of the said obligation to the Assignee the Assignor hereby assigns unto the Assignee all sums of money that shall be owing to the Assignor by the Minister for the above noted contract. The Minister is hereby authorized to pay all such sums directly to the Assignee at the address aforesaid, or at any address the Assignee may from time to time designate, with payment of any such sum to be sufficient discharge to the Minister of and from any indebtedness in that amount to the assignor, his heirs, executors, or administrator.

DATED this _____ *day of* _____ *year* _____

Signature of Assignor _____

WITNESS Signature _____ *Occupation* _____

ASSIGNMENT Effective From _____/_____/_____/ *TO* _____/_____/_____/
(First Date of Claim to Last Date) *Month Day Year* *Month Day Year*

GWL Certificate or I.D. Number _____ *GWL Plan Number/Employer* _____

M5502-5/10

Schedule "B"

AUTHORIZATION TO PROVIDE MEDICAL INFORMATION

I, _____
(patient)

(OR I _____
(insured if patient is a minor dependent)

Parent/Guardian of _____ *a minor)*

hereby consent to and authorize the Ministry of Health to furnish to any representative of The Great-West Life Assurance Company any and all records and information in the ministry of Health's possession regarding claims for Medical Services incurred while I had insurance coverage from (indicate trip dates) month _____ day _____ year _____ to month _____ day _____ year _____ including medical history and physical condition both prior and subsequent to receipt of Medical Services regardless of lapsed time and bearing in any way on the services received during the above time period.

DATED this _____ *day of* _____ *year* _____

Personal Health Number: _____

Signature: _____

Address: _____

_____

_____

Telephone Number: _____

BRITISH COLUMBIA | Health InsuranceBC

OUT-OF-COUNTRY CLAIM
(to be filled out by the beneficiary)

Return to:

IMPORTANT

- **Please read the instructions in Section D before completing this form**
- **Attach all original receipts or bills to this form – include itemized statement (receipts not in English must be translated before being submitted)**
- **Claims must be received within 90 days of the date of service**
- **If you leave Canada specifically to obtain medical care, you must receive prior approval for payment of insured services – see Section D, Elective Services on page 4**
- **This form must be completed and signed by the patient or their legal guardian**
- **Retain copies of bills or receipts for your records**

SECTION A – PATIENT INFORMATION

PATIENT LAST NAME	PATIENT FIRST NAME(S)	PERSONAL HEALTH NUMBER (PHN)

BIRTHDATE (DD / MM / YYYY)	GENDER	HOME PHONE NUMBER	WORK PHONE NUMBER
	☐ MALE ☐ FEMALE		

MAILING ADDRESS	CITY / TOWN	PROVINCE	POSTAL CODE

RESIDENTIAL ADDRESS (IF DIFFERENT FROM ABOVE)	CITY / TOWN	PROVINCE	POSTAL CODE

HAS PATIENT LIVED AT ABOVE ADDRESS FOR THE 6 MONTHS PRECEDING DEPARTURE FROM BC?

☐ YES ☐ NO IF NO, PROVIDE BELOW THE RESIDENTIAL ADDRESS(ES) WHERE PATIENT WAS LIVING

PREVIOUS RESIDENTIAL ADDRESS 1	CITY / TOWN	PROVINCE	POSTAL CODE	FROM (MM / YYYY)	TO (MM / YYYY)

PREVIOUS RESIDENTIAL ADDRESS 2	CITY / TOWN	PROVINCE	POSTAL CODE	FROM (MM / YYYY)	TO (MM / YYYY)

NAME AND ADDRESS OF PRESENT OR LAST EMPLOYER IN BRITISH COLUMBIA	EMPLOYER OF
	☐ PATIENT ☐ HEAD OF FAMILY

NAME AND ADDRESS OF A PERSON (NOT A RELATIVE) WHO CAN CONFIRM PATIENT'S RESIDENCE IN BRITISH COLUMBIA (INCLUDE POSTAL CODE)

REASON FOR ABSENCE FROM BRITISH COLUMBIA

☐ VACATION ☐ STUDENT
☐ MOVED ☐ BUSINESS TRIP
☐ OBTAIN MEDICAL CARE ☐ OTHER (SPECIFY):

	MONTH	DAY	YEAR
DATE OF DEPARTURE FROM BC			
DATE OF RETURN TO BC			

DO YOU HAVE EXTENDED HEALTH BENEFITS INSURANCE OR TRAVEL INSURANCE? ☐ YES ☐ NO	IF YES, NAME OF COMPANY	POLICY NUMBER

ARE YOU OR ANY DEPENDENTS COVERED BY HEALTH INSURANCE IN ANOTHER COUNTRY?

☐ YES ☐ NO ***If yes, attach statement of payment of claims***

RELEASE OF INFORMATION

I, the patient named above, hereby authorize Out-of-Country Claims, Medical Services Plan, to obtain information necessary for the processing of my claim from the Hospital and/or Doctor who provided care or in the event of an appeal on this case to provide the appeal board with the appropriate information in order for an informed decision to be made.

I also authorize Out-of-Country Claims, Medical Services Plan, to provide/obtain information to/from the above named travel insurance or extended health benefits company.

In addition, my signature below is my Application for Benefits under the *Hospital Insurance Act* of British Columbia (for in-patient hospital charges).

I certify that I am the person entitled to receive benefits and that all statements made by me are true and correct.

	If legal guardian, provide name and relationship to patient	
SIGNATURE OF PATIENT / LEGAL GUARDIAN	NAME OF LEGAL GUARDIAN	CONTACT PHONE NUMBER
	RELATIONSHIP TO PATIENT	
DATE SIGNED	RESIDENTIAL ADDRESS	

Personal information on this form is collected under the authority of the *Medicare Protection Act* and the *Hospital Insurance Act*. The information will be used to determine residency in BC and determine eligibility for provincial health care benefits. If you have any questions about the collection of this information, contact an MSP client representative at the address or telephone number shown in Section D of the form. Personal information is protected from unauthorized use and disclosure in accordance with the *Freedom of Information and Protection of Privacy Act* and may be disclosed only as provided by that Act.

SECTION B – TO CLAIM FOR DOCTOR'S FEE COMPLETE THIS SECTION

REASON FOR SEEKING MEDICAL ATTENTION (DIAGNOSIS)

TREATMENT / PROCEDURE	DURATION OF ANAESTHESIA _____ HRS _____ MIN OR FROM _____ TO _____
LABORATORY TESTS	AMOUNT PAID (ENCLOSE PROOF OF PAYMENT) $
SPECIFY EACH AREA X-RAYED	AMOUNT PAID (ENCLOSE PROOF OF PAYMENT) $

PHYSICIAN INFORMATION (if more than 7 physicians, attach additional page)

***AMOUNT PAID – ENCLOSE PROOF OF PAYMENT**

1	DOCTOR'S NAME AND SPECIALTY	COUNTRY AND CURRENCY	HAVE YOU PAID THE ACCOUNT? ☐ YES ☐ NO
	WERE YOU REFERRED BY ANOTHER DOCTOR? IF YES, PROVIDE NAME AND ADDRESS ☐ YES ☐ NO		
	DATE OF VISIT: MONTH DAY YEAR	TYPE OF VISIT ☐ OFFICE ☐ HOME ☐ HOSPITAL	TIME OF VISIT ☐ 8 AM - 6 PM ☐ 6 PM - 11 PM ☐ 11 PM - 8 AM	AMOUNT PAID** $
2	DOCTOR'S NAME AND SPECIALTY	COUNTRY AND CURRENCY	HAVE YOU PAID THE ACCOUNT? ☐ YES ☐ NO
	WERE YOU REFERRED BY ANOTHER DOCTOR? IF YES, PROVIDE NAME AND ADDRESS ☐ YES ☐ NO		
	DATE OF VISIT: MONTH DAY YEAR	TYPE OF VISIT ☐ OFFICE ☐ HOME ☐ HOSPITAL	TIME OF VISIT ☐ 8 AM - 6 PM ☐ 6 PM - 11 PM ☐ 11 PM - 8 AM	AMOUNT PAID** $
3	DOCTOR'S NAME AND SPECIALTY	COUNTRY AND CURRENCY	HAVE YOU PAID THE ACCOUNT? ☐ YES ☐ NO
	WERE YOU REFERRED BY ANOTHER DOCTOR? IF YES, PROVIDE NAME AND ADDRESS ☐ YES ☐ NO		
	DATE OF VISIT: MONTH DAY YEAR	TYPE OF VISIT ☐ OFFICE ☐ HOME ☐ HOSPITAL	TIME OF VISIT ☐ 8 AM - 6 PM ☐ 6 PM - 11 PM ☐ 11 PM - 8 AM	AMOUNT PAID** $
4	DOCTOR'S NAME AND SPECIALTY	COUNTRY AND CURRENCY	HAVE YOU PAID THE ACCOUNT? ☐ YES ☐ NO
	WERE YOU REFERRED BY ANOTHER DOCTOR? IF YES, PROVIDE NAME AND ADDRESS ☐ YES ☐ NO		
	DATE OF VISIT: MONTH DAY YEAR	TYPE OF VISIT ☐ OFFICE ☐ HOME ☐ HOSPITAL	TIME OF VISIT ☐ 8 AM - 6 PM ☐ 6 PM - 11 PM ☐ 11 PM - 8 AM	AMOUNT PAID** $
5	DOCTOR'S NAME AND SPECIALTY	COUNTRY AND CURRENCY	HAVE YOU PAID THE ACCOUNT? ☐ YES ☐ NO
	WERE YOU REFERRED BY ANOTHER DOCTOR? IF YES, PROVIDE NAME AND ADDRESS ☐ YES ☐ NO		
	DATE OF VISIT: MONTH DAY YEAR	TYPE OF VISIT ☐ OFFICE ☐ HOME ☐ HOSPITAL	TIME OF VISIT ☐ 8 AM - 6 PM ☐ 6 PM - 11 PM ☐ 11 PM - 8 AM	AMOUNT PAID** $
6	DOCTOR'S NAME AND SPECIALTY	COUNTRY AND CURRENCY	HAVE YOU PAID THE ACCOUNT? ☐ YES ☐ NO
	WERE YOU REFERRED BY ANOTHER DOCTOR? IF YES, PROVIDE NAME AND ADDRESS ☐ YES ☐ NO		
	DATE OF VISIT: MONTH DAY YEAR	TYPE OF VISIT ☐ OFFICE ☐ HOME ☐ HOSPITAL	TIME OF VISIT ☐ 8 AM - 6 PM ☐ 6 PM - 11 PM ☐ 11 PM - 8 AM	AMOUNT PAID** $
7	DOCTOR'S NAME AND SPECIALTY	COUNTRY AND CURRENCY	HAVE YOU PAID THE ACCOUNT? ☐ YES ☐ NO
	WERE YOU REFERRED BY ANOTHER DOCTOR? IF YES, PROVIDE NAME AND ADDRESS ☐ YES ☐ NO		
	DATE OF VISIT: MONTH DAY YEAR	TYPE OF VISIT ☐ OFFICE ☐ HOME ☐ HOSPITAL	TIME OF VISIT ☐ 8 AM - 6 PM ☐ 6 PM - 11 PM ☐ 11 PM - 8 AM	AMOUNT PAID** $

SECTION C – TO CLAIM FOR IN-PATIENT HOSPITAL CHARGES COMPLETE THIS SECTION

- **In-patient hospital charges include registered bed patient, dialysis, and surgical day care.**
- **Sections A and C must be completed in the fullest possible detail to confirm residency and entitlement for hospital benefits. See Section D for residency requirements.**
- **A separate application is required for each admission to hospital.**
- **If the condition of the person requiring admission to hospital does not permit him/her to apply on his/her own behalf, or if he/she is an underage dependent, this form should be completed by a member of the family or some other person having knowledge of the facts.**

NAME OF HOSPITAL

MAILING ADDRESS OF HOSPITAL, INCLUDING POSTAL CODE

ADMITTING DIAGNOSIS (NATURE OF ILLNESS) AND TREATMENT PROVIDED DURING HOSPITALIZATION

DATE OF ADMISSION: MONTH	DAY	YEAR	DATE OF DISCHARGE: MONTH	DAY	YEAR	HAVE YOU PAID THE HOSPITAL ACCOUNT? ☐ YES ☐ NO	AMOUNT PAID (ENCLOSE PROOF OF PAYMENT) $

ACCIDENTAL INJURY (If hospitalization was the result of an accidental injury, complete this section)

DATE OF ACCIDENT: MONTH	DAY	YEAR	ACCIDENT LOCATION

TYPE OF ACCIDENT

- ☐ AUTOMOBILE - (YOU WERE):
  - ☐ DRIVER IN TWO/MULTI-CAR COLLISION
  - ☐ PASSENGER IN TWO/MULTI-CAR COLLISION
  - ☐ PEDESTRIAN STRUCK BY AUTOMOBILE
  - ☐ CYCLIST STRUCK BY AUTOMOBILE
  - ☐ DRIVER IN AUTOMOBILE SHOW
  - ☐ PASSENGER IN AUTOMOBILE SHOW
- ☐ OTHER TYPE OF ACCIDENT (SPECIFY):

DESCRIBE HOW THE ACCIDENT TOOK PLACE

WHO DO YOU THINK WAS RESPONSIBLE FOR THE ACCIDENT?

NAMES, ADDRESSES AND INSURANCE INFORMATION (IF KNOWN) OF OTHER DRIVERS/PERSONS INVOLVED IN ACCIDENT

1

FULL NAME AND ADDRESS OF OTHER DRIVER / PERSON INVOLVED IN ACCIDENT

NAME AND ADDRESS OF OTHER DRIVER'S / PERSON'S INSURANCE COMPANY

POLICY NUMBER

2

FULL NAME AND ADDRESS OF OTHER DRIVER / PERSON INVOLVED IN ACCIDENT

NAME AND ADDRESS OF OTHER DRIVER'S / PERSON'S INSURANCE COMPANY

POLICY NUMBER

3

FULL NAME AND ADDRESS OF OTHER DRIVER / PERSON INVOLVED IN ACCIDENT

NAME AND ADDRESS OF OTHER DRIVER'S / PERSON'S INSURANCE COMPANY

POLICY NUMBER

SECTION D - GENERAL INFORMATION

EMERGENCY OUT-OF-COUNTRY MEDICAL TREATMENT

When an eligible B.C. resident is temporarily absent from the province and must use emergency medical services in another country, the provincial coverage is limited. For information about coverage, visit the Ministry of Health website: http://www.health.gov.bc.ca/msp/infoben/leavingbc.html

Medical Services Plan (MSP) coverage for emergency out-of-country, physician services is limited to the B.C. physician fee rates.

Provincial coverage for emergency out-of-country, in-patient hospital services is limited to $75.00 CDN per day.

Any difference in fees will be the beneficiary's responsibility.

If the claim indicates the out-of-country physician or hospital has not been paid, payment will be made directly to the out-of-country physician or hospital.

If the claim is for a small amount or if the out-of-country hospital or physician will not accept payment in Canadian currency, payment will be sent to the beneficiary and the beneficiary will be responsible to pay the account.

Please allow 12-16 weeks for processing.

ELECTIVE OUT-OF-COUNTRY MEDICAL TREATMENT

If a B.C. resident plans to leave Canada to obtain medical services in another country, provincial coverage for elective out-of-country medical services must be approved by MSP **PRIOR** to leaving BC. Important coverage information and the requirement for medical documentation is detailed on the Ministry of Health website: http://www.health.gov.bc.ca/msp/infoben/leavingbc.html#outsidecan

MSP DOES NOT PROVIDE COVERAGE FOR THE FOLLOWING:

- services that are not deemed to be medically required, such as cosmetic surgery
- dental office services
- routine eye examinations for persons 19 to 64 years of age
- eyeglasses, hearing aids, and other equipment or appliances
- annual or routine examinations where there is no medical need
- services of counsellors or psychologists
- certified physician assistant
- registered nurse/nurse practitioner
- prosthesis and appliances
- nurse anaesthetist
- health spas and similar facilities
- transportation and accommodation expenses
- supplies and materials
- use of emergency room, private clinic/surgical facility fees
- medical care at the request of a third party
- medical examinations, certificates or tests required for:
  - driving a motor vehicle
  - employment
  - life insurance
  - immigration purposes
  - school or university
  - recreational/sporting activities

PROVINCIAL COVERAGE IS NOT PROVIDED *OUTSIDE B.C.* FOR THE FOLLOWING:

- ambulance services
- prescription drugs
- midwife services
- massage therapy
- physical therapy
- naturopathy
- chiropractic
- podiatry
- acupuncture
- optometry
- home care services

DENTAL AND ORAL SURGICAL PROCEDURES

MSP coverage for Dental and Oral surgical procedures is limited to surgery that must be performed in an acute care hospital for patient safety and the medical complexity of the surgery. For detailed coverage information, visit the Ministry of Health website: http://www.health.gov.bc.ca/msp/infoben/benefits.html#benefits

For more information on submitting an Out-of-Country Claim, visit the Ministry of Health website:
https://www.health.gov.bc.ca/exforms/msp/occ.html

IF YOU REQUIRE FURTHER INFORMATION, CONTACT HEALTH INSURANCE BC AT:

Health Insurance BC
Out-of-Country Claims
PO Box 9480 Stn Prov Govt
Victoria BC V8W 9E7
Web: www.hibc.gov.bc.ca

Phone: 604 683-7151 (Lower Mainland)
1 800 663-7100 Toll-free (Rest of BC)
Fax: 250 405-3588

BEFORE MAILING: *Please ensure you have completed your claim form*
Attach all receipts or bills to this form – include itemized statements
Ensure that you have signed all appropriate areas