

INSTRUCTIONS

IMPORTANT

- All claims must be reported to Ontime Care Worldwide Inc. ("OTC") within 30 days of occurrence. Written proof of claim must be submitted to OTC within 90 days of occurrence.**
- You are responsible for all fees charged for completion of this form and any supporting documentation.**

Claims Submission

- To complete the claim submission, patients must obtain and submit to OTC a copy of the emergency room report and all hospital records if treated at a hospital. For patients treated at a medical clinic, medical centre or by a physician, a physician's medical report is required for claim submission.
- If you have paid for services, you must submit all original itemized invoices and payment receipts from the medical service provider or hospital detailing treatment and treatment dates.
- Complete all sections below and ensure this form is signed before submitting to OTC with all original invoices, physician and medical reports, and original prescription pharmacy receipts. Failure to complete the form or submit supporting documentation will delay processing.
- Please mail or drop off your claim submission to "15 Wertheim Court, suite 512, Richmond Hill, ON, L4B 3H7".**
If you have any questions, please contact us by email: claim@otcww.com or contact us by phone at 905-918-0188 (collect worldwide) or 1-888-988-3268 (toll free Canada/US)

SECTION A: CLAIMANT

Insured's First Name: _____ Last Name: _____

Male Female Date of Birth (MM/DD/YY): _____ Policy #: _____

Address in Canada

Street Address: _____

City/Town: _____ Province: _____ Postal Code: _____

Telephone: _____ Email address: _____

Country of Origin: _____ Date of Arrival in Canada: _____

Full Name of Guardian, if applicable: _____ Guardian's Phone #: (_____)

Name and Address of Treating Physician in Canada

Full Name: _____

Street Address: _____

City/Town: _____ Postal Code: _____ Telephone: (_____)

Name and Address of Family Physician in Country of Origin

Full Name: _____

Street Address: _____

City/Town: _____ Postal Code: _____ Telephone: (_____)

SECTION B: OTHER INSURANCE COVERAGE

Do you, your spouse or your parents/guardian have **any other medical or travel insurance coverage**? Yes No

If 'Yes', please provide name and address of other insurance company/coverage:

Full Name: _____

Street Address: _____

City/Town: _____ Postal Code: _____ Telephone: (_____)

SECTION C: MEDICAL INFORMATION

Brief description of your sickness or injury: _____

Date your symptoms first appeared or injury occurred (MM/DD/YY): _____

Date you first saw a physician for this condition (MM/DD/YY): _____

Have you ever been treated for this or a similar condition before? Yes No

If you answered "yes", provide all dates of treatment and list all medications taken before the effective date of the current policy:

Date (MM/DD/YY): _____ Medication: _____

Date (MM/DD/YY): _____ Medication: _____

SECTION D: MEDICAL / DENTAL EXPENSE CLAIMED

Name of Provider	Diagnosis / Description of services	Date of Service (MM/DD/YY)	Amount Billed (\$)	Amount Paid (\$)

Important: If submitting a dental claim, please attach a standard dental claim form fully completed and signed by your dentist for the treatment received

SECTION E: Payment Method

This claim is payable to: Insured at the address in Section A above Parent/Guardian Hospital/Clinic Physician Other

Please specify the desired payment method for this claim: By Cheque By email Transfer (For total claims under CAD\$500 only)

If by cheque, the cheque is payable to: _____

Mailing address: Same address in section A; Otherwise: _____

If by email transfer, Same email in section A; Otherwise: _____

Note: Email transfer option is only available for total claim submission under CAD\$500. You need to have email transfer set up with your financial institution to select this option.

SECTION F: AUTHORIZATION AND CERTIFICATION

Berkley Canada ("Berkley") and OTC, are committed to protecting the privacy, confidentiality and security of the personal information we collect, use, retain and disclose. Your personal information will be used only for the purposes of providing you with the requested insurance services.

I authorize any doctor, hospital or facility providing medical or health-related services, third-party administrator, and any other insurer to release and exchange with Berkley, OTC, or its representatives, any information that is required to process this claim. I assign to Berkley and OTC any benefits payable from any other sources for losses covered under this policy, and I authorize and direct such payors to forward payment directly to Berkley and OTC. I also authorize any third party providing me with assistance in this claims process to have access to any and all relevant claims information related to the adjudication of my claim with Berkley and OTC. I confirm that I am authorized to act on behalf of my dependents for these purposes.

I certify that the information provided in connection with this claim is complete, true and accurate.

Full Name of Patient/Insured (please print): _____

Signature of Insured (if under 18, signature of parent or legal guardian): _____

Signature of policyholder of *other insurance* in Section B (if applicable): _____

Date: (MM/DD/YY): _____