TRAVEL INSURANCE

Desjardins
Financial Security®

HOSPITAL AND MEDICAL EXPENSES CLAIM FORM
QUÉBEC RESIDENTS ONLY

CLAIM PROCEDURE

IMPORTANT

In order to process your request, we must ask you to complete this form and to **sign the *Mandate* section below and the *Signature and Authorization* section at the back**. This will enable us to file claims with the Régie de l'assurance maladie du Québec (RAMQ) on behalf of the insured.

Note: RAMQ does not return the original statements of account, invoices or receipts. Always keep a copy for your records.

All documents must be sent to: Travel Insurance Claims
200, rue des Commandeurs
Lévis (Québec) G6V 6R2

MANDATE

I, the undersigned, ______________________________ hereby
(please print)

specifically mandate the insurer, Desjardins Financial Security Life Assurance Company, to

1) submit to RAMQ, in accordance with the laws and regulations applied by RAMQ, claims on my behalf for insured medical and hospital services rendered to me, my spouse or my children

   at ______________________________
   (city, country)

   during my stay from Year Month Day (date) to Year Month Day (date)

   This section must be completed if other family members received medical attention during the trip.

   Spouse: ____________________ Health Insurance Card Nº: ____________________

   Child: ____________________ Health Insurance Card Nº: ____________________

   Child: ____________________ Health Insurance Card Nº: ____________________

2) provide to RAMQ and receive from it all information, documents or any other proofs needed for the study, assessment and payment of these claims.

3) receive from RAMQ the reimbursements made and payable to me, my spouse or my children.

I HEREBY AUTHORIZE RAMQ to approve the claims submitted hereunder on my behalf and to act according to this mandate, as well as to forward to the insurer any information it may request concerning my status of Insured or that of my spouse and children.

NOTE: RAMQ also requires a signature on the back of the form to process this request.

Signature of Insured ____________________ Health Insurance Card Number ____________________

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CONTINUED ON REVERSE

TRAVEL INSURANCE

APPLICATION FOR REIMBURSEMENT

INSURED HEALTH SERVICES RECEIVED OUTSIDE QUÉBEC

DO NOT WRITE IN THIS SPACE

Note: The beneficiary is the person who has received the care.

BENEFICIARY'S IDENTITY

HEALTH INSURANCE NUMBER — LETTERS / FIGURES

LAST NAME | LAST NAME AT BIRTH (IF DIFFERENT)

FIRST NAME | DATE OF BIRTH: YEAR / MONTH / DAY | SEX: M / F

① PERMANENT ADDRESS IN QUEBEC
NO. | STREET | APT | TOWN OR VILLAGE
PROVINCE | POSTAL CODE | TELEPHONE NUMBER AT HOME — AREA CODE | TELEPHONE NUMBER AT WORK — AREA CODE

② ADDRESS OUTSIDE QUEBEC
NO. | STREET | APT | TOWN OR VILLAGE
PROVINCE OR STATE AND COUNTRY | POSTAL CODE | TELEPHONE NUMBER AT HOME — AREA CODE | TELEPHONE NUMBER AT WORK — AREA CODE

CHEQUE TO BE MAILED TO: ☐ ADDRESS ① ☐ ADDRESS ②

INQUIRIES TO BE SENT TO: ☐ ADDRESS ① ☐ ADDRESS ②

STAY OUTSIDE QUEBEC

DATE OF DEPARTURE YEAR / MONTH / DAY

DATE OF RETURN ☐ ACTUAL ☐ PLANNED YEAR / MONTH / DAY

REASON FOR STAY OUTSIDE QUEBEC

☐ **VACATION OR PLEASURE TRIP** — Do you keep a residence outside Quebec? ☐ YES ☐ NO

☐ **WORK** — Employer's name
Do you keep a residence in Quebec? ☐ YES ☐ NO
Do you intend to return to Quebec within twelve months of your departure? ☐ YES ☐ NO

☐ **STUDIES** — Attach written attestation from educational institution with dates of your courses, unless you have already done so

☐ **MEDICAL CARE** — If you have applied to the Régie for authorization, enter reference number

☐ **OTHER** — Specify

OTHER STAYS OUTSIDE QUEBEC DURING THE YEAR

1st STAY						2nd STAY						3rd STAY					
DEPARTURE DATE			RETURN DATE			DEPARTURE DATE			RETURN DATE			DEPARTURE DATE			RETURN DATE		
YEAR	MONTH	DAY	YEAR	MONTH	DAY	YEAR	MONTH	DAY	YEAR	MONTH	DAY	YEAR	MONTH	DAY	YEAR	MONTH	DAY

PERMANENT MOVE

TO ANOTHER CANADIAN PROVINCE: Date of arrival in other province — YEAR / MONTH / DAY

ABROAD: Date of departure from Quebec — YEAR / MONTH / DAY

SERVICES RECEIVED

Give reason for receiving medical or hospital services

Describe services received (e.g. examination, X-rays, surgery) If you need more space, use separate sheet

List town and province (or country) where services were rendered

IF SERVICES WERE REQUIRED DUE TO AN ACCIDENT, SPECIFY
DATE OF ACCIDENT — YEAR / MONTH / DAY

TYPE OF ACCIDENT: ☐ ROAD ☐ WORK ☐ OTHER — SPECIFY

AMOUNT CLAIMED | CANADIAN CURRENCY ☐ | OTHER CURRENCY (SPECIFY) ☐

HAS THE BILL BEEN PAID? ☐ NO ☐ YES — IF YES ☐ IN FULL ☐ IN PART ▶ AMOUNT

Have you ever worked outside Canada? ☐ NO ☐ YES ▶ COUNTRY — FROM YEAR / MONTH / DAY — TO YEAR / MONTH / DAY

SIGNATURE AND AUTHORIZATION

I hereby declare, knowing that this declaration has the same force and effect as if made under oath and in virtue of the Canada Evidence Act, that the above information is accurate, and I authorize the Régie de l'assurance maladie du Québec (RAMQ) to obtain any further information it may require from the health professional or the hospital concerned.

If the services referred to in this Application for Reimbursement were rendered following a road accident, I authorize RAMQ to forward to the S.A.A.Q. copies of any documents I may have sent it or it may have sent me, in order to facilitate the processing of my claim.

IF THE BENEFICIARY IS NOT SIGNING THIS FORM, ENTER THE NAME OF THE PERSON WHO IS SIGNING ON HIS/HER BEHALF

RELATIONSHIP TO BENEFICIARY (FATHER, MOTHER, SPOUSE, GUARDIAN, ETC.)

SIGNATURE: — YEAR / MONTH / DAY