Desjardins
Financial Security®

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TRAVEL INSURANCE

Print Reset

Claim number:		Date of birth of patient:	
Policy number:		Dates of travel:	From: To:

AUTHORIZATION AND RELEASE

1. DIRECTION AND RELEASE

I _____ irrevocably direct and authorize the Ontario Ministry of Health and Long-Term Care ("the Ministry") to make payment in respect of my claim for out-of-country health services to Desjardins Financial Security Life Assurance Company directly and I hereby release the Ministry, upon payment to Desjardins Financial Security Life Assurance Company from any further claim or cause of action in connection therewith.

2. CONSENT

If providing consent for self:

I authorize the Ministry to collect my personal health information, consisting of:

- information relating to my receipt of health care services outside of Canada, and
- information relevant to the reimbursement of those services under the Health Insurance Act, R.S.O. 1990, c. H. 6

from Desjardins Financial Security Life Assurance Company, and authorize the Ministry to disclose such personal health information as may be required for the purpose of verifying my request for payment under the Health Insurance Act, including the details of any duplicate payment previously made to me, to Desjardins Financial Security Life Assurance Company.

I understand the purpose for the Ministry's collection and disclosure of this personal health information.

I understand that I can refuse to sign this consent form.

Note: A substitute decision-maker is a person authorized under PHIPA to consent, on behalf of an individual, to disclose personal health information about the individual.

_____ _____

Date

Signature of or on behalf of insured if patient is less than sixteen years of age

Health insurance card number of person who received the medical services

Version Code