



Please print your Firm & Certificate #

Firm #

Certificate #

T R A V E L H E A L T H C L A I M

Please read these instructions carefully before completing the form:

- Please print clearly and answer all questions. All the information you provide on this form will be treated as confidential.
Enclose itemized receipts for all services received along with a copy of the payment advice from your government plan.
Keep a copy of this claim for your records.

Chambers of Commerce Group Insurance Plan, 582 King Edward Street, Winnipeg, Manitoba R3H 0P1
Call 1-800-665-3365, Fax (204) 774-6698 or 1-800-457-8410

Employee's Last Name Employee's Given Name(s)

Employee's Full Mailing Address Date of Birth (D/M/Y)

Patient's Name Relationship to Employee Date of Birth (D/M/Y)

Departed from Home Province (D/M/Y) Originally Scheduled Return (D/M/Y) First Treatment (D/M/Y)

Are you or your dependents eligible for benefits under any other insurance plan? Yes No If Yes complete the following

Insurer's Name

Policy or Contract Number Person Insured

This claim is the result of a sudden illness (go to next section) an accident (complete the rest of this section)

Type of Accident Location of Accident

Date of Accident Name and Address of Lawyer Representing You With Respect to the Accident

Details of Accident

Why did you need medical attention? What was the nature of the illness or injury?

Attending Physician Name Were you hospitalized? No Yes

Address If No, who provided treatment?

Name Address

Family Physician at Home Name Address

Name Hospital Name

Address Address

STATEMENT OF EXPENSES (Attach receipts)

Table with 4 columns: Description, Organization Name on Billing, Date of Service, Amount/Currency. Rows include Hospital, Ambulance, Prescription Drugs, Other, and TOTAL.

ALL DOCUMENTS MUST BE TRANSLATED TO ENGLISH/FRENCH PRIOR TO SUBMISSION.

I certify that this claim is true and correct and agree that it shall be subject to the provisions of the Group Policy. I hereby authorize any physician, hospital, dentist, insurance company or organization to release any information regarding the medical history, treatment, disability or benefits payable for this claim to the Chambers of Commerce Group Insurance Plan or Desjardins Financial Security. A photocopy of this authorization shall be as valid as the original.

I understand that the fees listed in this claim may not be covered or may exceed my group insurance benefits. I understand that I am financially responsible for the entire cost of services received and that this claim is for reimbursement of eligible charges.

Date Residence Phone Business Phone

Employee's or Legal Representative's Signature