Visitors to Canada Claim Form (VCF1407)

PLEASE ENSURE THAT ALL QUESTIONS ARE ANSWERED THOROUGHLY AND DOCUMENTATION REQUESTED (BELOW) IS SUBMITTED WITH THIS CLAIM FORM. FAILURE TO ENCLOSE THIS INFORMATION MAY RESULT PROCESSING YOUR CLAIM.

TO REPORT A CLAIM, call 1-877-882-2957 toll-free USA and Canada. If unable to use the toll-free number, call collect to Canada: +1 519-251-7856.
TO ENQUIRE ABOUT THE STATUS OF YOUR CLAIM, call 1-855-297-4379 from 8:00AM to 8:00PM ET.
Instructions: You will need to complete this claim form and submit the following documents to:
21st Century Visitor's Claims, c/o Active Care Management, P.O. Box 1237, Station A, Windsor, ON N9A 6P8

a) copy of your completed application for insurance or your policy confirmation;
b) proof of all travel dates of entry into Canada and the USA (airline ticket, passport or visa);
c) original itemized medical bills, receipts and invoices;
d) proof of payment;
e) complete medical and/or hospital records including diagnosis, x-ray, lab or other diagnostic testing results, which confirm that the treatment was medically necessary; and,
f) copy of police report (in the case of a Motor Vehicle Accident).

Personal Information (to be completed by Insured/Sponsor)

Male: ☐ Female: ☐	Date of Birth : MM/DD/YYYY	Country of Origin :	Date of Arrival in Canada : MM/DD/YYYY	Policy Number :

Name of Insured :
Last First

Name of Sponsor :
Last First

Address in Canada : Telephone Number:

Purpose of Visit to Canada: Visitor Landed Immigrant/Permanent Resident Work Visa Student Visa Refugee Claimant
Other, please explain:

Do you have other similar government, private, or group insurance or a credit card providing similar coverage? ☐ Yes ☐ No
If YES, please provide policy details:

Name and address of your physician in your Country of Origin:

Claim Details (to be completed by Insured/Sponsor) Note: If there is insufficient space to provide your description below, please attach additional sheets.

Description of Injury or Sickness which required medical attention, and the cause:

Date symptoms first appeared or date of accident: MM/DD/YYYY	Date when medical treatment was first received: MM/DD/YYYY

Have you been diagnosed or showed symptoms of this condition prior to this occurrence? Yes No
If YES, provide date and name of doctor/facility which treated you:

Names, telephone numbers and addresses of all physicians seen for this Injury or Sickness during your trip:

Complete if the treatment was received in the USA	Date of Arrival in the USA: MM/DD/YYYY	Planned Date of Return from the USA: MM/DD/YYYY	Actual Date of Return from the USA: MM/DD/YYYY

Declaration and Consent (to be completed by Insured/Sponsor)

I declare the answers to each of the above questions on this claim form to be true to the best of my knowledge and belief. Any fraudulent act, misrepresentation or omission committed in the submission of a claim will void the coverage available under this Policy.

In order to facilitate the further administration of the above policy, and particularly the claims process, I authorize The Manufacturers Life Insurance Company (Manulife Financial) and its authorized representatives/agents (including 21st Century Travel Insurance Limited) to collect, use and disclose my personal information as permitted by law and for the purposes necessary to underwrite, investigate, adjudicate and settle claims; detect and prevent fraud; validate information provided; and exchange information with health professionals, assessors, valuators and other insurance related service or information providers, as dictated by prudent insurance industry practices. I understand that the Company will not collect or disclose medical or financial information without my further express consent, except as provided for herein or in the policy or as otherwise permitted by law. I hereby authorize the Company and its representatives/agents to collect and use or disclose my personal information as is necessary to administer the policy, provide services and process claims, which includes the investigation and handling of this matter.

I authorize any hospital, physician or their medical service provider, or any other organization or person that has any records or knowledge of me and my health to release to third party administrators, and Manulife Financial, agents and its reinsurers, any such information for the purpose of this claim.

Check here if you wish to have the proceeds of your claim made payable to your sponsor:
☐ I hereby authorize and direct Manulife Financial to make the proceeds of this claim made payable to my Sponsor, as follows:

Sponsor Name Address Postal Code Telephone

Signature of Insured/Patient: _____ Date: _____

If this form was completed by a Sponsor:

Print Name: _____ Relationship to Insured: _____

Signature : _____ Date: _____

Attending Physician's Statement

To be completed by the Physician – use a separate form for each condition

NOTE: If there is insufficient space to provide your description below, please attach additional sheets.

Charges for the completion of this form are the patient's responsibility

Name of Patient: Last First	Date of Birth: MM/DD/YYYY
Reason for Visit/Presenting Complaint:	
Diagnosis of Presenting Complaint:	
Reason for Visit: ☐ Emergency/urgent care (initial visit) ☐ Emergency/urgent care (follow-up) ☐ Check-up ☐ Renewal of medication ☐ Healthcare assessment for Immigration purposes ☐ Other, please explain:	
Date of Current Visit:	MM/DD/YYYY
When did patient first consult you for this condition?	MM/DD/YYYY
Date symptoms first appeared or date of accident:	MM/DD/YYYY
If accident, please provide details:	
Will follow-up treatment be required? If Yes, provide details:	☐ Yes ☐ No
Is patient medically/physically able to return to country of origin after current visit? If No, why and when will the patient be fit to travel?	☐ Yes ☐ No
From patient's case history has he/she ever had the same or similar complaint prior to the first consultation date with you? If YES, please provide details:	☐ Yes ☐ No
Did another physician treat the patient for this condition?	☐ Yes ☐ No
Was patient hospitalized for the current condition? If Yes, please provide details (i.e. name of hospital and period of hospitalization):	☐ Yes ☐ No
Was surgery performed? If YES, please provide details:	☐ Yes ☐ No
Was this condition related to the use of alcohol, misuse of drugs or self-inflicted injury?	☐ Yes ☐ No
Was this condition related to pregnancy?	☐ Yes ☐ No

Physician Certification:
I certify that the information provided in this section is correct and true to the best of my knowledge and belief:

Signature

Date

Name of Physician (please print)

Specialty

Physician's Stamp:

Physician's Address

Telephone Number