



OUT OF PROVINCE / COUNTRY CLAIM FORM

CLAIMING INSTRUCTIONS

1. THIS FORM IS USED FOR REIMBURSEMENT CLAIMS IF WORLD ACCESS CANADA HAS NOT BEEN CONTACTED.
2. THIS FORM IS TO BE COMPLETED BY THE PLAN MEMBER.
3. ALL CLAIMS MUST BE ASSESSED BY YOUR GOVERNMENT HEALTH INSURANCE PLAN (GHIP) FIRST.
4. PLEASE ATTACH A COPY OF YOUR STATEMENT OF PAYMENT OR DENIAL FROM YOUR GHIP.
5. RECEIPTS / INVOICES WILL NOT BE RETURNED. PLEASE KEEP COPIES FOR YOUR RECORDS.

PART 1 EMPLOYEE STATEMENT

GROUP NUMBER	CERTIFICATE NUMBER	NAME OF EMPLOYER
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NAME _____
 ADDRESS _____ POSTAL CODE _____

Are you, your spouse or dependents eligible for the claimed expenses under any of the following plans:

Spouse's employer / retiree plan:	YES <input type="checkbox"/>	NO <input type="checkbox"/>	If yes, provide insurance carrier name and policy number: _____
Credit Card(s):	YES <input type="checkbox"/>	NO <input type="checkbox"/>	If yes, provide insurance carrier name and policy number: _____
Travel Insurance:	YES <input type="checkbox"/>	NO <input type="checkbox"/>	If yes, provide insurance carrier name and policy number: _____
Home / Auto insurance:	YES <input type="checkbox"/>	NO <input type="checkbox"/>	If yes, provide insurance carrier name and policy number: _____
Other (specify) _____	YES <input type="checkbox"/>	NO <input type="checkbox"/>	If yes, provide insurance carrier name and policy number: _____

PART 2 PATIENT INFORMATION

NAME _____ DATE OF BIRTH : Month () Day () Year ()
 RELATIONSHIP TO EMPLOYEE _____ SEX: MALE FEMALE

PART 3 CLAIM DETAILS

1. Provide the reason for your out of Province / Country visit: _____
2. Provide the date of departure from your Province / Country of residence: Month () Day () Year ()
3. Provide the date of return to your Province / Country of residence: Month () Day () Year ()
4. Provide the date of accident / illness: Month () Day () Year ()
5. Provide the location (city, country) of your accident / illness: _____
6. Provide diagnosis: _____

Total Amount Claimed	\$ _____	Currency	_____
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PART 4 EMPLOYEE AUTHORIZATION

Notice Concerning Personal Information

You have previously provided consent to Wawanesa Life for the collection, use and disclosure of your personal information for the purposes of: establishing and maintaining communications with you; underwriting risks on a prudent basis; investigating and paying claims; detecting and preventing fraud; offering and providing products and services to meet your needs and compiling statistics and acting as required or authorized by law. That consent applied to personal information being provided to Wawanesa Life at that time and to personal information that may be provided after that time.

You can obtain further information about Wawanesa Life's Personal Protection Policy from the Wawanesa Life Head Office at 200-191 Broadway, Winnipeg, MB R3C 3P1 or at www.wawanesalife.com.

Authorization

I have read the above Notice Concerning Personal Information. I authorize the release of information in respect of this claim to Wawanesa Life. I further certify that the information on this form is true and complete.

Employee Signature _____ Date _____