JF ELITE PLUS STUDENT INSURANCE CLAIM FORM

IMPORTANT

- All claims must be reported to Ontime Care Worldwide within 90 days of occurrence.
- Written proof of claim must be submitted to Ontime Care Worldwide within 90 days of occurrence.
- You are responsible for all fees charged for completion of this form and any supporting documentation.
- Failure to complete and sign this form in its entirety or submit supporting documentation will delay claim processing.

CLAIMS SUBMISSION

- Complete all sections and ensure this form is signed before submitting to Ontime Care Worldwide with all original invoices, physician and medical reports detailing treatment and treatment dates, and prescription pharmacy receipts. Keep a copy for your records.
- Claimants must attach a copy of the emergency room report and all hospital records if treated at a hospital or a physician's medical report if treated at a medical clinic/centre or by a family physician.
- **Send all documents to Ontime Care Worldwide: Suite 512, 15 Wertheim Court, Richmond Hill, Ontario, L4B 3H7**
- **Questions can be emailed to <general@otcww.com> or via toll-free phone at 1-866-209-5804**

SECTION A: CLAIMANT

Claimant's First Name: _____ Claimant's Last Name: _____

Date of Birth (MM/DD/YY): _____ Age: _____ Policy #: _____ Group #: _____ ID #: _____

❑ Male ❑ Female Educational Institution: _____

Enrollment Date: (MM/DD/YY): _____ Arrival Date in Canada: (MM/DD/YY): _____

Full Name of Guardian, if applicable: _____ Guardian's Phone #: (_____) _____

CLAIMANT'S ADDRESS WHILE IN CANADA

Street Address: _____ City/Town: _____

Province: _____ Postal Code: _____ Telephone: (_____) _____ Cellular: (_____) _____

Email address: _____ Country of Origin: _____

DETAILS OF TREATING PHYSICIAN IN CANADA

Full Name: _____ Clinic Name or Practice: _____

Street Address: _____

Country: _____ Postal Code: _____ Telephone: (_____) _____ Alt. Telephone: (_____) _____

DETAILS OF FAMILY PHYSICIAN IN HOME COUNTRY

Full Name: _____ Clinic Name or Practice: _____

Street Address: _____

Country: _____ Postal Code: _____ Telephone: (_____) _____ Alt. Telephone: (_____) _____

Date you first saw a physician for a similar or related condition (MM/DD/YY): _____ ❑ Not applicable

SECTION B: OTHER INSURANCE COVERAGE

Do you, your spouse or your parents/guardians have **any other medical or travel insurance** coverage? ❑ Yes ❑ No

If yes, provide details of other insurance company coverage below. **If no**, confirm by checking the box below.

Full Name: _____ Employee Name: _____

Street Address: _____

City/Town: _____ Country: _____ Telephone: (_____) _____

❑ **If "No" is selected above, I hereby warrant that I do not have any other travel or medical insurance coverage.**

JF ELITE PLUS STUDENT INSURANCE CLAIM FORM

SECTION C: CLAIM INFORMATION

Description of your sickness or injury:_____

_____

Date of injury/Date symptoms first occurred (MM/DD/YY):_____

Date you first saw a physician for this injury or illness condition (MM/DD/YY):_____

Dates of treatment and all medications taken **before** the effective date of the current policy:

Treatment Date (MM/DD/YY):_____ Medications: _____

SECTION D: MEDICAL EXPENSES CLAIMED

Name of Provider	Nature of Injury / Diagnosis	Name of Referring Physician	Date of Service (MM/DD/YY)	Amount Billed ($)

SECTION E: DENTAL EXPENSES CLAIMED

Important: Attach a standard dental claim form fully completed and signed by your dentist for the treatment received.

Name of Provider	Description of Services	Date of Service (MM/DD/YY)	Tooth / Surface	Amount Billed ($)	Amount Paid ($)

SECTION F: AUTHORIZATION AND CERTIFICAITON

Berkley Canada ("Berkley"), Ontime Care Worldwide ("Ontime"), its agents and administrators are obliged to collect and retain certain personal and/or health information about you in connection with your insurance coverage. We use and disclose this information only for the purposes of administering your policy/policies of insurance, providing customer service and assessing and paying claims. We are committed to protecting the privacy, confidentiality and security of the personal information we collect, use, retain and disclose. Your personal information will be used only for the purposes of providing you with the requested insurance services. Berkley's and Ontime's complete privacy policies are available upon request.

I authorize any doctor, medical practitioner, hospital or facility providing medical or health-related services, third-party administrator, and any other insurer to release and exchange with Berkley, Ontime, or its representatives, any information (including personal health data and records) required to process this claim. I authorize any third party providing me with assistance in this claim process to have access to any and all relevant claims information related to the adjudication of my claim with Berkley and Ontime. I authorize Ontime to coordinate the payment of benefits with any insurance carriers that may have a liability for this claim and assign to Berkley and Ontime any benefits payable from any other sources for losses covered under this policy, and authorize and direct such payers to forward payment directly to Berkley and Ontime. I confirm below by my signature that I am authorized to act on behalf of any of my dependants for these purposes. A photocopy of this authorization shall be as valid as the original.

I certify that the information provided in connection with this claim is complete, true and accurate.

Name of Insured (please print): _____

If insured is a minor, print full name of parent or legal guardian: _____

Signature of Insured (if minor, signature of parent or legal guardian): _____

Signature of policyholder of *other insurance* in Section B (if applicable): _____

This claim is payable to ❑ Insured at the address in Section A above ❑ Parent/Guardian ❑ Hospital/Clinic ❑ Physician ❑ Other

If applicable, I authorize payment of this claim to (print name): _____

Date signed: (MM/DD/YY): _____