AUTHORIZATION, CONSENT AND RELEASE FOR RESIDENTS OF ONTARIO

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 Old Republic Insurance Company of Canada/Reliable Life Insurance Company directly and I hereby release OHIP, upon payment to Old Republic Insurance Company of Canada/Reliable Life Insurance 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,
- information relevant to the reimbursement of those services under the Health Insurance Act, R.S.O. 1990, c. H.6

from Old Republic Insurance Company of Canada/Reliable Life Insurance 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 Old Republic Insurance Company of Canada/Reliable Life Insurance 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.

If providing consent on behalf of a person who is not capable of consenting to the collection, use and disclosure of personal health information:

I _____ am the substitute decision-maker for _____. I authorize the Ministry to collect personal health information about the Insured Person, consisting of:

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

from Old Republic Insurance Company of Canada/Reliable Life Insurance 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 Old Republic Insurance Company of Canada/Reliable Life Insurance 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.

3. Authorization

My Name: _____

Home Tel: _____

Work Tel: _____

Address: _____

Signature: _____

Date: _____

Witness Name: _____

Home Tel:_____

Work Tel: _____

Address: _____

Signature:_____ _____

Date: _____

Claims Administration
OLD REPUBLIC INSURANCE COMPANY OF CANADA
RELIABLE LIFE INSURANCE COMPANY
Box 557, 100 King Street West
Hamilton, Ontario L8N 3K9
Toll Free: 888.831.2222
Fax: 866.551.1704

EMERGENCY MEDICAL CLAIM FORM

Please Note: *Benefits under any coverage will not be paid for expenses reimbursed or services provided by any other source. Benefits cannot be duplicated under this Protection Plan.*

PROOF OF CLAIM MUST BE SUBMITTED WITHIN 90 DAYS OF THE OCCURRENCE

Part I GENERAL INFORMATION

Claimant's Name *(Last, First)*		Policy No.	Date of Birth
Full Address			
Home Phone No.	Business Phone No.	**Government Health Insurance No.**	**Version Code**
Tour Operator's Name			
Travel Agency's Name		Travel Agent's Name	Telephone No.
Travel Agency's Full Address			
Date Initial Deposit Paid for Trip *(MM / DD / YY)*	Departure Date *(MM / DD / YY)*	Scheduled Return Date *(MM / DD / YY)*	Actual Return Date *(MM / DD / YY)*
Departure City		Destination *(City, Country)*	

Part II EXPLANATION OF LOSS

Describe fully the circumstances of the sickness or injury			
Date of onset of sickness or injury *(MM / DD / YY)*	Location *(City, Country)*		
Date of first consultation *(MM / DD / YY)*	Name of Physician who treated you		Were you hospitalized? ❑ Yes ❑ No
If yes, name of hospital		Admission date *(MM / DD / YY)*	Discharge date *(MM / DD / YY)*
Did you contact the Assistance Provider? ❑ Yes ❑ No	If yes, date contact was made *(MM / DD / YY)*	Have you ever had the same or similar condition? ❑ Yes ❑ No	If yes, when did the condition occur? *(MM / DD / YY)*
Were you prescribed medication? ❑ Yes ❑ No	Were the prescriptions/dosages changed prior to trip departure? ❑ Yes ❑ No	If Yes, please indicate the date *(MM / DD / YY)*	Name of Family Physician
Full address of Family Physician			Telephone No.

IMPORTANT – CLAIM CANNOT BE PROCESSED IF THIS FORM IS INCOMPLETE. PLEASE COMPLETE ALL APPLICABLE AREAS.

Part III MEDICAL EXPENSES

Name of Medical Service Provider/Doctor	Date of Service *(MM / DD / YY)*	Amount on Invoice *(IN CDN $)*	Did you pay this invoice?	Name of other Health Insurance Company/Plan Invoice submitted to	Amount paid by other Insurance Company/Plan	Amount claimed *(IN CDN $)*
					Total Amount Claimed in CDN $	

If you have more expenses, please provide a breakdown on an additional sheet using the above format.

Part IV OTHER COVERAGE

Do you have any other Health Insurance coverage/plans?
(e.g. Medicare, Blue Cross, Work Place/Group Insurance, Credit Cards, etc) ❑ Yes ❑ No

IF YES, PLEASE COMPLETE:

1) Name of Insurance Company	Policy No.	Telephone No.
Address of Insurance Company		
2) Name of Insurance Company	Policy No.	Telephone No.
Address of Insurance Company		

Was your medical emergency caused by an accident? ❑ Yes ❑ No	Name of the Third Party
	Full address of the Third Party
If yes, do you believe a Third Party was responsible? ❑ Yes ❑ No	Contact No. of the Third Party

IMPORTANT – **PLEASE ENCLOSE ORIGINAL RECEIPTS FOR ALL MEDICAL EXPENSES.**

IF CLAIM HAS BEEN SUBMITTED TO ANOTHER INSURANCE COMPANY, PLEASE PROVIDE AN EXPLANATION OF BENEFITS ONCE CLAIM HAS BEEN SETTLED, AS WELL AS THE "PATIENT RESPONSIBILITY" INVOICES SHOWING THE OUTSTANDING BALANCE.

I DECLARE THAT THE ABOVE INFORMATION IS TRUE, COMPLETE AND CORRECT.
I/We authorize any other insurance plan, under which I/We have coverage, to disclose information as may be necessary or to make payment in respect of my/our claim to Old Republic Insurance Company of Canada/Reliable Life Insurance Company directly. I/We also authorize Old Republic Insurance Company of Canada/Reliable Life Insurance Company to disclose to any other Plan, under which I/We have coverage, any and all information as may be necessary with respect to my/our claim.

Signature of Insured/Claimant _____ Date *(MM / DD / YY)* _____

Signature of Insured/Claimant _____ Date *(MM / DD / YY)* _____

Part V PATIENT CONSENT TO DISCLOSE HEALTH INFORMATION

Patient's full name at time of treatment: _____

Date of birth: (MM/DD/YY) _____ | _____ | _____

Address: _____

Purpose of release: **ADJUDICATION OF TRAVEL INSURANCE CLAIM**

Effective Date of Insurance Coverage: (MM/DD/YY) _____ | _____ | _____

Medical Facilities: (List all doctors consulted for this condition and hospitals where confined)

Name	*Address*	*Telephone No.*	*Fax No.*	*Dates*
_____	_____	_____	_____	_____ | _____ | _____
_____	_____	_____	_____	_____ | _____ | _____
_____	_____	_____	_____	_____ | _____ | _____

You are authorized to give **Old Republic Insurance Company of Canada/Reliable Life Insurance Company** and its affiliates, reinsurers, agents, consumer reporting agency, or independent claims administrator acting on behalf of Old Republic Insurance Company of Canada/Reliable Life Insurance Company, any information concerning insurance coverage, medical care, advice, treatment or supplies, or any other information that may have bearing on the request for benefits submitted in conjunction with the travel insurance policy.

Information to be released:

All medical records of the Patient for up to 5 years before the Effective Date of Insurance Coverage as shown above through the date of this consent as shown below as applicable based on the patients age as outlined the policy. "Medical records" includes, without limitation, diagnosis list, medication list, physician dictation, office notes, physical therapy records, occupational therapy records, pathology reports, cytology reports and the results of all laboratory tests.

Send to: **Travel Claims Department**
P.O. Box 557, 100 King St. W.
Hamilton, ON L8N 3K9
Telephone: 1-888-831-2222 Fax: (905) 528-8338

By signing below, I understand that:

1. The information in my health record may include information relating to a sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
2. I have the right to revoke this consent at any time by providing my written revocation to the facility where my records are kept.
3. A revocation will not apply to information that has already been released in response to this consent.
4. A revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
5. Unless otherwise revoked, this consent will expire in six months.
6. Consenting to the disclosure of this health information is voluntary. I can refuse to sign this consent.
7. Any disclosure of information carries with it the potential for any unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

I authorize Old Republic Insurance Company of Canada/Reliable Life Insurance Company to disclose my health or claim information to any relevant source (e.g. airline, tour operator, travel suppliers, etc.) for the purpose of obtaining recoveries or any outstanding refunds after my insurance claim has been settled. I hereby assign to Old Republic Insurance Company of Canada/Reliable Life Insurance Company any benefits or recoveries obtained from these sources for losses covered under this policy. I direct these sources to forward reimbursement to Old Republic Insurance Company of Canada/Reliable Life Insurance Company with regard to these losses.

Signature of patient or authorized person: _____ Date: (MM/DD/YY) _____ | _____ | _____

Relationship/Reason patient is unable to sign: _____