PACIFIC BLUE CROSS®

DO NOT WRITE IN THIS SPACE

VISITORS TO CANADA CLAIM FORM

Mail: PO Box 7000, Vancouver, BC V6B 4E1 | Drop it off: 4250 Canada Way, Burnaby, BC | pac.bluecross.ca

- Please read instructions on reverse before submitting this form. Ensure you have completed all sections.
- Enclose all original receipts. Keep a copy of the receipts for your records.
- For help completing this form, please call us at 604 419-2000 or 1 877 PAC-BLUE.

PART 1 — MEMBER INFORMATION

Plan Member's last name	Plan Member's first name	Plan #/Certificate #

Plan Member's permanent resident address

Plan Member's Canada address	Postal code	Daytime phone number

Send cheque to: ☐ Permanent resident address ☐ Canada address

Send correspondence to: ☐ Permanent resident address ☐ Canada address

PART 2 — CLAIMANTS INFORMATION

1 Name of claimant	Relationship to member	Birth date (mm-dd-yyyy)
2 Name of claimant	Relationship to member	Birth date (mm-dd-yyyy)

Does the claimant have any other coverage which may consider these charges? ☐ Yes ☐ No		Do you or the claimant(s) have a "Gold Credit Card" or any credit cards which may provide travel insurance ☐ Yes ☐ No Expiry date:	
Travel insurance name:	ID/policy #	Bank:	ID/Card #/policy #
Extended Health carrier:	ID/policy #	Trust Company:	ID/Card #/policy #
Other coverage:	ID/policy #	Credit Union:	ID/Card #/policy #

Have you claimed or notified any of the above carriers? ☐ Yes ☐ No	If "yes", please indicate the date you notified them (dd-mm-yyyy)	If "no", please do not claim with them

Country where expenses incurred:

Date of arrival in Canada (mm-dd-yyyy)	Date of return to your place of residence (mm-dd-yyyy)

Reason(s) for absence from your province of residence:

☐ Vacation ☐ Student ☐ Work ☐ Moved ☐ Obtain medical treatment

Are injuries the result of a motor vehicle accident? ☐ Yes ☐ No	Is there a person or entity who is liable for your injuries? ☐ Yes ☐ No

Are you taking legal action against a person or entity? If "yes", call the Pacific Blue Cross at 604 419-2600 for claiming instructions.

☐ Yes ☐ No

PART 3 — PLAN MEMBER'S STATEMENT AND CLAIMANT'S AUTHORIZATION FOR RELEASE OF INFORMATION

I certify that the information given on this form is true, correct, and complete to the best of my knowledge. I authorize Pacific Blue Cross to obtain/provide information from/to the provincial medical plan, any doctor, hospital, clinic, person, institution, or other carriers that may have a responsibility in this claim.

I also authorize Out of Country Claims to provide/obtain information to/from the travel insurance or extended health care company that I have named.

Assignment of Payment: I authorize Pacific Blue Cross to make payments directly to providers or suppliers for outstanding charges, which are payable benefits under this claim. For payments made on my behalf, I authorize any other carriers to assign eligible benefits to Pacific Blue Cross.

Pacific Blue Cross does not return receipts. Please save our "Explanation of Benefits" for income tax purposes. If you also have coverage with another insurance company, make photocopies of all receipts before sending the originals to Pacific Blue Cross.

Plan member's signature **X**	Date (mm-dd-yyyy)
Parent's signature or parent/guardian if claimant is a minor **X**	Date (mm-dd-yyyy)

PART 4 — HOW TO CLAIM - Visitors to Canada medical expenses

- Please read instructions on reverse before submitting this form. Ensure you have completed all sections.
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1	Name of doctor, hospital, clinic or other expensew	Date of service or purchase (dd-mm-yyyy)	Amount billed (in foreign currency)	For PBC use	For PBC use	For PBC use Balance
	Was treatment due to an emergency? ☐ Yes ☐ No	Details of illness or injury				Have you paid the account? ☐ Yes ☐ No
2	Name of doctor, hospital, clinic or other expensew	Date of service or purchase (dd-mm-yyyy)	Amount billed (in foreign currency)	For PBC use	For PBC use	For PBC use Balance
	Was treatment due to an emergency? ☐ Yes ☐ No	Details of illness or injury				Have you paid the account? ☐ Yes ☐ No
3	Name of doctor, hospital, clinic or other expensew	Date of service or purchase (dd-mm-yyyy)	Amount billed (in foreign currency)	For PBC use	For PBC use	For PBC use Balance
	Was treatment due to an emergency? ☐ Yes ☐ No	Details of illness or injury				Have you paid the account? ☐ Yes ☐ No
4	Name of doctor, hospital, clinic or other expensew	Date of service or purchase (dd-mm-yyyy)	Amount billed (in foreign currency)	For PBC use	For PBC use	For PBC use Balance
	Was treatment due to an emergency? ☐ Yes ☐ No	Details of illness or injury				Have you paid the account? ☐ Yes ☐ No
5	Name of doctor, hospital, clinic or other expensew	Date of service or purchase (dd-mm-yyyy)	Amount billed (in foreign currency)	For PBC use	For PBC use	For PBC use Balance
	Was treatment due to an emergency? ☐ Yes ☐ No	Details of illness or injury				Have you paid the account? ☐ Yes ☐ No
6	Name of doctor, hospital, clinic or other expensew	Date of service or purchase (dd-mm-yyyy)	Amount billed (in foreign currency)	For PBC use	For PBC use	For PBC use Balance
	Was treatment due to an emergency? ☐ Yes ☐ No	Details of illness or injury				Have you paid the account? ☐ Yes ☐ No

Were you treated by a physician for the above illness/injury prior to your departure?
☐ Yes ☐ No

If "yes", please specify the condition(s)

Name of your family doctor	Telephone

Family doctor's address