JF Insurance Agency Group Inc.

OPTIMUM PLUS VISITOR TO CANADA EMERGENCY HOSPITAL & MEDICAL INSURANCE CLAIM FORM

OTC ONTIME CARE WORLDWIDE INC.

INSTRUCTIONS

IMPORTANT

- **All claims must be reported to Ontime Care Worldwide Inc. ("OTC") within 30 days of occurrence. Written proof of claim must be submitted to OTC within 90 days of occurrence.**
- **You are responsible for all fees charged for completion of this form and any supporting documentation.**
- **We reserve the right to request submission of the original documentation or additional information if needed.**

Claims Submission

- To complete the claim submission, patients must obtain and submit to OTC a copy of the emergency room report and all hospital records if treated at a hospital. For patients treated at a medical clinic, medical centre or by a physician, a physician's medical report is required for claim submission.
- If you have paid for services, you must submit all itemized invoices and payment receipts from the medical service on provider or hospital detailing treatment and service dates.
- There are two ways to submit your claim:
  1. Online:
     For claims with total expenses less than $500, submit your claim with supporting receipts and reports online at eclaim.jfgroup.ca. (For claims over $500, please submit by mail)
  2. By Mail:
     Mail your completed claim form, original receipts, medical reports to:
     Ontime Care Worldwide, 15 Wertheim Court, Suite 512, Richmond Hill, ON, L4B 3H7
     Please ensure to keep a copy of your claim for your own records.
- Failure to fill out the claim sections fully or provide supporting documentation will delay processing.
- If you have any questions, please contact us by email: claim@otcww.com or contact us by phone at 905-707-3335

SECTION A: CLAIMANT

Insured's First Name:_____ Last Name:_____

❑ Male ❑ Female Date of Birth (MM/DD/YY):_____ Policy #:_____

Address in Canada

Street Address:_____

City/Town:_____ Province:_____ Postal Code:_____

Telephone:_____ Email address:_____

Country of Origin:_____ Date of Arrival in Canada:_____

Name and Address of Treating Physician in Canada

Full Name:_____ Street Address:_____

City/Town:_____ Postal Code:_____ Telephone: ( )_____

Name and Address of Family Physician in Country of Origin

Full Name:_____ Street Address:_____

City/Town:_____ Postal Code:_____ Telephone: ( )_____

SECTION B: OTHER INSURANCE COVERAGE

Do you have other insurance coverage including Canadian government health insurance? ❑ Yes ❑ No

Do you have insurance coverage through your spouse? ❑Yes ❑ No If 'Yes', please provide name and address of other insurance company/coverage:

Full Name:_____ Street Address:_____

City/Town:_____ Postal Code:_____ Telephone: ( )_____

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SECTION C: MEDICAL INFORMATION

Brief description of your sickness or injury:_____

_____

Date your symptoms first appeared or injury occurred (MM/DD/YY):_____

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

Have you ever been treated for this or a similar condition before? ❑ Yes ❑ No

If you answered "yes", provide all dates of treatment and list all medications taken before the effective date of the current policy:

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

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

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

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

SECTION D: EXPENSES CLAIMED

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

SECTION E : Payment Method

Please specify the desired payment method for this claim: ❑ By Cheque ❑ By email Transfer (For total claims under CAD$500 only)

If by cheque, the cheque is payable to: _____

Mailing address: ❑ Same address in section A; Otherwise: _____

If by email transfer, ❑ Same email in section A; Otherwise: _____

Note: Email transfer option is only available for total claim submission under CAD$500. You need to have email transfer set up with your financial institution to select this option.

SECTION F: AUTHORIZATION AND CERTIFICATION

I understand that the personal information provided with respect to this claim is required by the insurer, administrator, and agents ("we") for the purpose of assessing entitlements to benefits and administering this claim. We may disclose the information collected to third parties within and outside of Canada for the purpose of providing assistance with administering your claim.

All active personal information will be retained and stored within Canada for a period of ten years.
I authorize and consent to the release, exchange, or disclosure of my personal or medical information with any medical provider, healthcare facility, insurance company, reinsurer, government department and/or legal representative with Ontime Care Worldwide Inc. (OTC), its underwriter, plan administrator, agent or representative for the purpose of assessing, investigating, administering, processing and/or subrogating this claim.

I further acknowledge I have the right to withdraw consent to the processing of my personal information as described within this authorization; however, any withdrawal of consent may prevent OTC from being able to process my claim.

I authorize any doctor, hospital or facility providing medical or health-related services, third-party administrator, and any other insurer to release and exchange with CUMIS General Insurance Company, OTC, or its representatives, any information that is required to process this claim. I assign to OTC any benefits payable from any other sources for losses covered under this policy, and I authorize and direct such payors to forward payment directly to OTC.

I also authorize any third party providing me with assistance in this claims process to have access to any and all relevant claims information related to the processing of my claim with OTC. I confirm that I am authorized to act on behalf of my dependents for these purposes.

I certify that the information provided in connection with this claim is complete, true and accurate. I understand that any incomplete, misleading or false information may lead to my coverage being voided, the payment of my claim denied, claim payments that were made in error being recovered from me, or any combination of the aforementioned being taken by OTC.

I acknowledge and agree that entering my name in the signature line below constitutes my signature, acceptance, and agreement to all of the terms and conditions provided herein with the same binding effect whether signed manually or electronically. Delivery of this claim form bearing an electronic signature by way of email in portable document format (PDF) shall have the same effect as if it were physically delivered.

Full Name of Patient/Insured (please print): _____

Signature of Insured (if under 18, signature of parent or legal guardian): _____

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

Date: (MM/DD/YY): _____