GlobalExcel®

MANDATE

Policy No. _____

Claim No. _____

1. I, the undersigned, hereby authorize any hospital, physician, or medical facility to send my medical information to Global Excel Management Inc., authorized representatives of the insurer. I further consent to the disclosure of this information by Global Excel Management Inc. to other sources as may be required to obtain benefits from other sources.

I, the undersigned, _____ hereby empower
BLOCK LETTERS

the Royal & Sun Alliance Insurance Company of Canada:

2. To submit to the *Régie de l'assurance maladie du Québec* (the Régie), in accordance with the laws and regulations applied by the Régie, my claims for insured medical and hospital services which I, my spouse or my children (family insurance) received in

_____
CITY, STATE, COUNTRY

during our stay there extending from _____ to _____
DATE DATE

3. To transmit to, and receive from, the Régie all information and documents required for the assessment and payment of said claims.
4. To receive from the Régie all amounts reimbursed and due to me, my spouse and children (family insurance).
5. I warrant that neither I nor any Insured Person have any additional coverage through any other insurer (other than that listed below).
6. I understand that my insurance shall be void if, whether before or after the loss, any person has concealed or misrepresented any fact or circumstance concerning this claim.

I hereby authorize the Régie to accept the claims so submitted, to act in accordance with this Mandate as specified and to transmit to Royal & Sun Alliance Insurance Company of Canada any information it may request concerning the beneficiary status of myself, my spouse or my children.

_____ _____
BENEFICIARY'S (CLAIMANT'S) SIGNATURE **PROVINCIAL HEALTH INSURANCE NO.**

OTHER INSURANCE

Are you covered by U.S. Medicare? ❒ Yes ❒ No

Do you have group benefits through (check all that apply)

- your Employer ❒ Yes ❒ No
- your Spouse's Employer ❒ Yes ❒ No
- a Retiree plan ❒ Yes ❒ No

Please provide details:

Name of employee/retiree _____ Date of birth of insured _____ M / D / Y

Relationship _____

Name of employer/group _____ Policy/plan no. _____

Name of insurance company _____ ID no. _____

Company's telephone no. (_____) _____ - _____

Company's address _____

Does the policy have a lifetime cap? ❒ Yes ❒ No

If yes, cap maximum: $ _____

Do you have other travel insurance? ❒ Yes ❒ No

Do you have any out-of-country benefits through (check all that apply)?

- Home insurance ❒ Yes ❒ No
- Auto insurance ❒ Yes ❒ No
- Other: _____ ❒ Yes ❒ No

☎ For Claim inquiries, call:
1 800 336-9224 or **819 566-8698**

Please provide details: Name of insurance company _____ Policy/ID no. _____

Telephone no. (_____) _____ - _____

Do you have Credit Card Coverage? ❒ Yes ❒ No

If yes, card no. _____ Card type/bank _____

Name of cardholder _____

I, the undersigned, hereby assign to Global Excel Management Inc. any benefits obtainable from other sources for covered losses under this policy. I also direct these sources to forward payment to Global Excel Management Inc. with regard to these losses and to exchange information that facilitates this process.

Claimant's or authorized _____ **Date** _____
PERSON'S SIGNATURE

FOR COMPANY USE ONLY

Fraud Verification A: **Fraud Verification B:**

50 36 MDT EQC 1208 000

PLEASE COMPLETE THE OTHER SIDE OF THIS FORM

Régie de l'assurance-maladie du Québec

To be completed if you reside in the Province of Quebec

APPLICATION FOR REIMBURSEMENT

INSURED HEALTH SERVICES RECEIVED OUTSIDE QUEBEC

DO NOT WRITE IN THIS SPACE

SELECT THE APPROPRIATE BOX Health services received: ❑ in Canada ❑ outside Canada

IDENTITY

HEALTH INSURANCE NUMBER (LETTERS / FIGURES)	LAST NAME	LAST NAME AT BIRTH (IF DIFFERENT)
	FIRST NAME	DATE OF BIRTH (YEAR / MONTH / DAY) — SEX ❑ M ❑ F

1 PERMANENT ADDRESS IN QUEBEC

NO | STREET | APT. | TOWN OR VILLAGE

PROVINCE OR STATE AND COUNTRY | POSTAL CODE | TELEPHONE NUMBER AT HOME AREA CODE | TELEPHONE NUMBER AT WORK AREA CODE

2 ADDRESS OUTSIDE QUEBEC

NO | STREET | APT. | TOWN OR VILLAGE

PROVINCE OR STATE AND COUNTRY | POSTAL CODE | TELEPHONE NUMBER AT HOME AREA CODE | TELEPHONE NUMBER AT WORK AREA CODE

CHEQUE TO BE MAILED TO: ❑ ADDRESS 1 ❑ ADDRESS 2 **INQUIRIES TO BE SENT TO:** ❑ ADDRESS 1 ❑ ADDRESS 2

STAY OUTSIDE QUEBEC

Stay during which you received the health services

DATE OF DEPARTURE (YEAR / MONTH / DAY) **DATE OF RETURN TO QUEBEC** ❑ ACTUAL ❑ PLANNED (YEAR / MONTH / DAY)

REASON FOR STAY OUTSIDE QUEBEC (SELECT ONE REASON ONLY)

- ❑ **vacation or pleasure trip**
- ❑ **work** — Employer's name: .....
- ❑ **studies** — Attach written attestation from educational institution with dates of your courses, unless you have already done so
- ❑ **receive medical care not available in Quebec** — If you have aplied to the Régie for authorization, enter reference number .....
- ❑ **permanent move** ❑ within Canada ❑ outside Canada DATE OF MOVE (YEAR / MONTH / DAY)
- ❑ **other** — Specity .....

For any other stays outside Quebec **of more than 21 consecutive days** during the calendar year (January 1st to December 31st), specify:

	DEPARTURE DATE (YEAR / MONTH / DAY)	RETURN DATE (YEAR / MONTH / DAY)
1ST STAY		
2ND STAY		
3RD STAY		

HEALTH SERVICES RECEIVED

Give reason for receiving medical or hospital services

IF AN ACCIDENT, INDICATE THE TYPE OF ACCIDENT ❑ ROAD ❑ WORK ❑ OTHER (specify)

DATE OF THE ACCIDENT (YEAR / MONTH / DAY)

Describe the services received (e.g.: exams, x-rays, surgery) If you need more space, use separate sheet.

WHERE WERE THE SERVICES RENDERED? CITY	PROVINCE (CANADA) OR STATE (U.S.)	COUNTRY	IN THE CASE OF HOSPITALIZATION IINDICATE THE NUMBER OF DAYS:

REIMBURSEMENT

AMOUNT CLAIMED	CANADIAN CURRENCY	OTHER CURRENCY	SPECIFY:	HAS THE BILL BEEN PAID?	AMOUNT (provide original receipt)
	❑	❑		❑ NO ❑ YES — ❑ IN FULL ❑ IN PART	

SIGNATURE AND AUTHORIZATION

I hereby affirm, knowing that this affirmation shall have the same force and effect as if it had been made under oath in accordance with the Canada Evidence Act, that the above information is accurate, and I authorize the RAMQ to obtain any further information it may require from the health professional or the hospital concerned. If charges apply to obtain this information, I understand that I am responsible for these.

If the services referred to in this Application for Reimbursement were rendered following a road accident or a work accident, I authorize the RAMQ to forward copies of the enclosed documents to the SAAQ or the CSST in order to facilitate the processing of my claim.

IF THE BENEFICIARY IS NOT SIGNING THIS FORM, ENTER THE NAME OF THE PERSON WHO IS SIGNING ON HIS/HER BEHALF

RELATION TO BENEFICIARY (FATHER, MOTHER, SPOUSE, GUARDIAN, ETC.)

SIGNATURE (YEAR / MONTH / DAY)

LANGUAGE OF CORRESPONDENCE ❑ ENGLISH ❑ FRENCH