CLAIM FORM

INSTRUCTIONS

IMPORTANT

- All claims must be reported to Intrepid 24/7 within 90 days of occurrence.
- Written proof of claim must be submitted to Intrepid 24/7 within 90 days of occurrence.
- You are responsible for all fees charged for 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 Intrepid 24/7 with all invoices, physician and medical reports detailing treatment and treatment dates, and prescription pharmacy receipts. Keep copies for your records.
- Claimants must attach a copy of the emergency room report and all hospital records if treated at a hospital.

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): _____

CLAIMANT'S ADDRESS WHILE IN CANADA

Street Address: _____ City/Town: _____

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

Email address: _____ Country of Origin: _____

DETAILS OF FAMILY PHYSICIAN IN COUNTRY OF ORIGIN (IF AVAILABLE)

Full Name: _____ Clinic Name or Practice: _____

Street Address: _____ City/Town: _____

Country:_____ Postal Code: _____ Telephone: (_____) _____ Fax: (_____) _____

DETAILS OF TREATING PHYSICIAN IN CANADA

Full Name: _____ Clinic Name or Practice: _____

Street Address: _____ City/Town: _____

Country: _____ Postal Code: _____ Telephone: (_____) _____ Fax: (_____) _____

SECTION B: OTHER INSURANCE COVERAGE

Is the claimant covered by another medical or travel insurance policy (including coverage through a spouse, parent, or guardian)?

☐ Yes ☐ No

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

Full Name: _____ Insurance Company: _____

Employer Name (if applicable): _____Policy/Plan #: _____

Employer Group (if applicable): _____ ID/Certificate #: _____

Employer Phone # (if applicable): _____

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

SECTION C: CLAIM INFORMATION

Description of your sickness or injury (if this space proves insufficient, additional information can be attached):

_____

_____

_____

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

Have you ever been treated for this, or a similar or related, condition before? ☐ Yes ☐ No

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

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

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

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

SECTION D: EXPENSES CLAIMED

Name of Provider	Reason for visiting the doctor & Diagnosis	Date of Service (MM/DD/YY)	Amount Billed ($)	Amount Paid ($)

SECTION E: AUTHORIZATION AND CERTIFICATION

Berkley Canada ("Berkley"), Intrepid 24/7 ("Intrepid"), 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 in 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 Intrepid'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, Intrepid, 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 Intrepid. I authorize Intrepid to coordinate the payment of benefits with any insurance carriers that may have a liability for this claim and assign to Berkley and Intrepid 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 Intrepid. 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 a minor, signature of parent or legal guardian): _____

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

SECTION F: ASSIGNMENT OF BENEFITS

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): _____