ONEWORLD ASSIST

DOCUMENTATION REQUIREMENTS

EMERGENCY DENTAL CLAIMS

Below is a list of required claim forms and additional information, needed to process your recent claim. Please review each item carefully and complete it as accurately and as fully as possible. Be sure to sign each form as indicated. In addition, provide all ORIGINAL receipts, bills and/or prescription receipts.

Please provide the following documents and information:

- ☑ **Dental claim form**
  - Please fully complete this form.
  - The Medical Authority on the front of the form must be signed.
  - In Section 3, please remember to sign the bottom of this section, warranting you have disclosed all additional coverages. (Reminder: if information is incomplete or inaccurate, your claim may be null and void)
  - If you list additional coverage in Section 3, you must also sign Section 4.

- ☑ **All ORIGINAL, itemized bills/receipts.**

- ☑ **All ORIGINAL prescription drug receipts** (pharmacy issued tax or customer receipts).

- ☑ **Proof of payment**
  - If you have already paid the dental provider or facility directly, please provide proof of the amount paid so we can process your reimbursement.
  - For example, “paid” receipt from the provider, credit card statement, copy of a cancelled cheque, etc.

- ☑ **Written statement (if your claim is related to DENTAL PAIN)**
  - Please provide a written statement detailing the diagnosis or the nature of the dental pain you are claiming for.
  - Wherever possible, please include the dates and times of your consultations, and the name, address and telephone number of the dentist that treated you.

- ☑ **Written statement (if your claim is related to a DENTAL INJURY)**
    - Please provide a written description of the event which caused your dental injury. Be sure to include the date and time of the incident as well as the name, address and telephone number of who you feel is responsible.
    - If possible, please also include the name, address and telephone number of the dentist that treated you for the injury.

As we are unable to process your claim until this information is received, please provide all of the requested information as soon as possible.

Thanks for your assistance.

OneWorld Assist looks forward to resolving your claim.

Dental Claim

ONEWORLD ASSIST

This form will be returned if both sides are not completed in full

OneWorld Assist, 10th Floor, 6081 No.3 Road
Richmond, BC Canada V6Y 2B2
Tel: 604-278-4108 **Fax**: 604-276-4593
Canada & USA Toll Free: 1-800-663-0399

Claim No.

ISO 9001 REGISTERED KPMG

CANADA'S BEST MANAGED COMPANIES

(Please print clearly)

1. GENERAL INFORMATION

Name of the Insured claiming ___ FIRST NAME ___ FAMILY NAME ___ ❍ M ❍ F

Address ___ City ___ Prov. ___

Postal code ___ Telephone: Home [ ] ___ Office [ ] ___

Policy number ___ Date of birth M | D | Y

Country where claim occurred ___

Departure date from home province M | D | Y Return date to home province M | D | Y

Date that dental pain began or accident occurred ___

Date that dental treatment was first obtained ___

Description of circumstances leading to dental claim ___

Amount paid by you to dentist ___ Currency paid ___

Balance due directly to dentist ___

Name, address and telephone number of your usual dentist ___

2. MEDICAL AUTHORITY

AUTHORIZATION TO PHYSICIANS, HOSPITALS AND OTHER MEDICAL PROVIDERS

(This form will be returned to the sender if not completed and signed as indicated.)

1. I authorize all hospitals, physicians, medical care providers, insurers and other persons, from all countries, to provide to OneWorld Assist Inc. ("OWA") all information and documentation in their possession that OWA requires to process my claim, including: records in regard to illnesses, injuries, medical history, consultations, medicines and treatments of the claimant named below (collectively, the "Medical Records").
2. I authorize OWA to collect, use and disclose the Medical Records, and the information in the Medical Records, to the selling agent, and to any insurers, including government health plans, that may have a responsibility in this claim.
3. I understand that the purpose for the collection, use and disclosure of the Medical Records is to enable OWA and insurers to assess and determine the eligibility of any claim I might submit. I acknowledge and agree that it is my responsibility to provide to OWA such information and other documentation as may reasonably be required to process my claim and that my failure to do so will jeopardize my entitlement to coverage.
4. I understand that if Medical Records are required from the U.S., this purpose constitutes a payment operation under the privacy rules in the U.S. Health Insurance Portability and Accountability Act.
5. This authorization takes effect on the date set out below. I understand that I may revoke this authorization in writing. I acknowledge and agree that if this authorization is revoked before the Medical Records are collected and reviewed my entitlement to insurance coverage will be jeopardized.

A copy of this authorization received from OWA shall be as effective and valid as the original.

FIRST NAME ___ FAMILY NAME ___

Print name **(and relationship if not claimant)**

X ___

Signature **(Claimant or authorized representative)**

M | D | Y

Date

PLEASE COMPLETE REVERSE SIDE

3. OTHER INSURANCE (If claimant is a dependent, provide requested information for parents or guardians.)

Do you have any group benefits available for medical coverage through your employer, your spouse's employer or a retirement plan? ❍ Yes ❍ No
If "Yes", please provide details below:

	Name of Insurance Co.	Telephone #	Group Policy#	Member ID#	Lifetime limit
Your employer/retirement plan	______	______	______	______	$______
Spous'e employer/retirement plan	______	______	______	______	$______

Spouse's name ______ FIRST NAME FAMILY NAME ______ Spouse's date of birth ___ M | D | Y ___

Do you have benefits available through any other travel insurance company or travel supplier? ❍ Yes ❍ No If "Yes", please provide:

Name of other provider ______________________ Policy #______________

Address of other provider ______________________________

Did you use a credit card for any of your travel arrangements? (many credit cards offer travel benefits) ❍ Yes ❍ No If "Yes", please provide:

Name of issuing financial institution ______________________________

Card number ______________________ ______________________

FIRST NAME FAMILY NAME ______ **X** ______________ M | D | Y ______
Name of cardholder (please print) Cardholder signature (if different from insured) Date

I warrant that I do not have any other travel or out-of-country medical insurance coverage.

X ______________ FIRST NAME FAMILY NAME ______ M | D | Y ______
Signature (claimant or authorized representative) Print name Date

4. CLAIMANT'S ASSIGNMENT OF PAYMENT

I assign to OneWorld Assist Inc. ("OWA") any benefits obtainable from other sources for covered losses. For payments made on my behalf, I authorize any other carriers to assign eligible benefits to OWA.

A copy of this authorization received from OWA shall be as effective and valid as the original.

FIRST NAME FAMILY NAME ______
Print full name (and relationship if not claimant)

X______________ M | D | Y ______
Signature (claimant or authorized representative) Date

X______________ M | D | Y ______
Signature of primary policy holder of other insurance in Section 3 above (if applicable) Date