

Appendix A — Authorization and Release Specifications Involving a Minor

1. DIRECTION AND RELEASE

I, _____ personally or as the authorized custodial parent for _____ (the Insured Patient) irrevocably direct and authorize the Ontario Ministry of Health and Long-Term Care ("the Ministry") to make payment in respect of my claim, or if applicable, the Insured Patient's claim, for out-of-country health services directly to Global Excel Management Inc. ("GEM") and hereby release the Ministry, upon payment to GEM, from any further claim or cause of action in connection therewith.

Note: An authorized substitute/proxy is a person authorized under PHIPA to consent, on behalf of an individual, to disclose personal health information about the individual.

2. CONSENT

I authorize the Ministry to collect my/the insured patient's personal health information, consisting of:

- information relating to my/the insured patient's receipt of health care services outside of Canada, and
- information relevant to the reimbursement of those services under the Health Insurance Act, R.S.O. 1990, c. H.6

from GEM, and authorize the Ministry to disclose such personal health information as may be required for the purpose of verifying my/the insured patient's request for payment under the Health Insurance Act, including the details of any duplicate payment previously made to my/the insured patient, to GEM.

I understand the purpose for the Ministry's collection and disclosure of this personal health information.

You have the right to refuse to sign this consent form, however, GEM and the Ministry will be unable to process your/the insured patient's claim if this form is unsigned.

3. AUTHORIZATION

Custodial Parent Name: _____

My/The Insured Patient's Name: _____ Address: _____

Home Telephone: _____ Work Telephone.: _____

Signature: _____ Date: _____

YOUR/INSURED PATIENT'S

ONTARIO HEALTH INSURANCE NUMBER: _____ **YOUR/INSURED PATIENT'S VERSION CODE*:** _____

Witness Name: _____ Address: _____

Home Telephone: _____ Work Telephone.: _____

Witness' Signature: _____ Date: _____

Important: Accurately completing all details will assist us in settling your/the insured patient's claim promptly.

Please attach original bills or receipts when submitting your/the insured patient's claim. We recommend you keep copies for your own records.

* Depending on the date your/the insured patient's Ontario Health Card was issued or renewed, your/the insured patient's **VERSION CODE** may be two letters, one letter, or you/the insured patient may not yet have a **VERSION CODE**.

 For claim inquiries, call **1-800-336-9224** or **819-566-8698**.

❖❖❖❖ Please complete the other side of this form ❖❖❖❖