



MANDATE

Policy No. _____

Claim No. _____

GlobalExcel®

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



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	LAST NAME	LAST NAME AT BIRTH (IF DIFFERENT)		
LETTERS FIGURES	FIRST NAME	DATE OF BIRTH YEAR MONTH DAY		SEX <input type="checkbox"/> M <input type="checkbox"/> 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

<p>Stay during which you received the health services</p> <p>DATE OF DEPARTURE: YEAR MONTH DAY DATE OF RETURN TO QUEBEC: <input type="checkbox"/> ACTUAL <input type="checkbox"/> PLANNED YEAR MONTH DAY</p> <p>REASON FOR STAY OUTSIDE QUEBEC (SELECT ONE REASON ONLY)</p> <p><input type="checkbox"/> vacation or pleasure trip</p> <p><input type="checkbox"/> work Employer's name:</p> <p><input type="checkbox"/> studies Attach written attestation from educational institution with dates of your courses, unless you have already done so</p> <p><input type="checkbox"/> receive medical care not available in Quebec If you have applied to the Régie for authorization, enter reference number</p> <p><input type="checkbox"/> permanent move <input type="checkbox"/> within Canada <input type="checkbox"/> outside Canada DATE OF MOVE: YEAR MONTH DAY</p> <p><input type="checkbox"/> other Specify:</p>	<p>For any other stays outside Quebec of more than 21 consecutive days during the calendar year (January 1st to December 31st), specify:</p> <p>1ST STAY</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td>DEPARTURE DATE YEAR MONTH DAY</td> <td>RETURN DATE YEAR MONTH DAY</td> </tr> </table> <p>2ND STAY</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td>DEPARTURE DATE YEAR MONTH DAY</td> <td>RETURN DATE YEAR MONTH DAY</td> </tr> </table> <p>3RD STAY</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td>DEPARTURE DATE YEAR MONTH DAY</td> <td>RETURN DATE YEAR MONTH DAY</td> </tr> </table>	DEPARTURE DATE YEAR MONTH DAY	RETURN DATE YEAR MONTH DAY	DEPARTURE DATE YEAR MONTH DAY	RETURN DATE YEAR MONTH DAY	DEPARTURE DATE YEAR MONTH DAY	RETURN DATE YEAR MONTH DAY
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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 INDICATE THE NUMBER OF DAYS:
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REIMBURSEMENT

AMOUNT CLAIMED	CANADIAN CURRENCY <input type="checkbox"/>	OTHER CURRENCY <input type="checkbox"/> SPECIFY:	HAS THE BILL BEEN PAID?	AMOUNT (provide original receipt)
			<input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> IN FULL <input type="checkbox"/> 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.

<p>IF THE BENEFICIARY IS NOT SIGNING THIS FORM, ENTER THE NAME OF THE PERSON WHO IS SIGNING ON HIS/HER BEHALF</p>	<p>RELATION TO BENEFICIARY (FATHER, MOTHER, SPOUSE, GUARDIAN, ETC.)</p>	<p>LANGUAGE OF CORRESPONDENCE <input type="checkbox"/> ENGLISH <input type="checkbox"/> FRENCH</p>
SIGNATURE	YEAR MONTH DAY	