

SCHEDULE "A"

ASSIGNMENT OF PAYMENT DUE TO BENEFICIARY UNDER THE SASKATCHEWAN MEDICAL CARE INSURANCE ACT OR THE SASKATCHEWAN HOSPITALIZATION ACT

BETWEEN _____ of the first part, (the **Assignor**)
(Claimant name)

AND Global Excel Management Inc. of the second part, (the **Assignee**)

AND Her Majesty the Queen in the Right of the Province of Saskatchewan as Represented by the Minister of Health (the **Minister**)

WHERE AS the Assignor is a person eligible for medical services under Saskatchewan Medical Care Insurance Act or the Saskatchewan Hospitalization Act or both, and as such may receive payment for the above services from the Minister.

WHERE AS the Assignor is under covenant or obligation under a contract of insurance with the assignee to remit to the Assignee to remit to the Assignee all such payments received for medical services from the Minister.

NOW WITNESS THAT in consideration of the said obligation to the Assignee the Assignor hereby assigns unto the Assignee all sums of money that shall be owing to the assignor by the Minister for the above noted contract. The Minister is hereby authorized to pay all such sums directly to the Assignee at the address aforesaid, or at any address the Assignee may from time to time designate, his heirs, executors, or administrators.

DATED this _____ day of _____, 20_____.

SIGNATURE OF ASSIGNOR

Witness:

Assignment:
Effective from: ____ / ____ / ____ to ____ / ____ / ____
(travel dates) M D Y M D Y

Signature

Occupation

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AUTHORIZATION TO PROVIDE MEDICAL INFORMATION

I, _____ hereby consent to and authorize the department of Health to furnish to any representative of Global Excel Management Inc., claim and paymnet information in the Department of Health,s possession in respect of claims for Medical Services incurred while I had insurance coverage from ____ / ____ / ____ to ____ / ____ / ____
M D Y M D Y

including payment and claim information for the period within 6 months prior to the date of service of the aforementioned Medical Services including physician/hospital name, date of service, and service profided (in-patient, out-patient, visit, procedure, x-ray or laboratory service or other medical treatment).

DATED this _____ day of _____, 20_____.

Personal Health Number

SIGNATURE

Address

Telephone

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