Claim Form

Underwritten by

HUMANIA ASSURANCE MD®

VUMI® CANADA

This Claim Form should only be used if the provider did not send a request directly to VUMI® Canada, Inc. and its subsidiaries or affiliates on its behalf. Send this form together with the invoices or receipts with the amounts broken down, diagnoses, and medical prescriptions to the address below.

Claim Form Requirements:

- Complete this form and submit along with all corresponding information within 180 days from the initial date of service. If the information is not received within the established period, the claim will not be covered.
- Present one claim form per event, per family member.
- Attach invoices detailing all services received as well as proof of payment for expenses incurred.
- All services rendered inside the United States must be accompanied by the Release of information form in order to obtain medical information from the provider if necessary.

Send this Claim Form with invoices and/or receipts to:

- Claimscanada@vumigroup.com.

Section I. **Claimant** information

1. Claimant's full name:

2. Date of birth: M M / D D / Y Y Y Y

3. Policyholder's full name:

4. Policy number:

5. E-mail address:

Section II. **Medical** information

1. Diagnosis:

2. Main symptoms:

3. Date of onset of symptoms: M M / D D / Y Y Y Y

4. Projected treatment or procedure and prognosis:

5. Has there been a prior diagnosis and/or treatment for the same or another related condition? ◯ Yes ◯ No

6. Date of first consultation: M M / D D / Y Y Y Y

7. If the answer is yes, provide dates, results, type of treatment, prescribed medications, and name of the doctor or hospital:

DOES THE PATIENT ALSO HAVE COVERAGE FROM:

8. Another health insurance plan? ◯ Yes ◯ No

9. If the answer is yes, provide the name and address of the other insurer:

WAS THE ILLNESS OR INJURY, IN ANY WAY, A RESULT OF:

10. The patient's profession? ◯ Yes ◯ No

11. An accident of any type? ◯ Yes ◯ No
(in case of an automobile accident, include a police report)

12. If the answer is yes, provide details, including the date of the accident:

DOCTOR / HOSPITAL INFORMATION:

1. Doctor's name / department / provider:

2. Phone number: + - -

3. Address:

4. Alternative phone number: + - -

5. Doctor's signature: X .....

6. E-mail address:

7. Treating physician's stamp: X .....

If the doctor information section is completed, signed and stamped by the treating physician this form will be valid as a medical report.

Section III. **Detailed invoice** information

MEDICAL SERVICES

DATE OF SERVICE (FROM / TO)		DESCRIPTION OF PROCEDURES, MEDICAL SERVICES AND SUPPLIES FURNISHED	CURRENCY	CHARGES
		TOTAL CHARGES:		
		AMOUNT PAID BY THE INSURED:		

PRESCRIBED MEDICATION

NAME OF THE PRESCRIBED MEDICATION	DIAGNOSIS	DATE	NAME OF PRESCRIBING DOCTOR	CURRENCY	CHARGES
			TOTAL CHARGES:		
			AMOUNT PAID BY THE INSURED:		

Section IV. **Reimbursement** information

PAYMENT METHOD

◯ Bank Transfer (attach a copy of a void cheque)

Bank Name: _____ Bank Address: _____

Account Holder: _____ Institution Number: _____ Transit Number: _____

Account Number: _____ SWIFT code: _____

◯ Apply reimbursement to the premium (please complete the information below)

I authorize VUMI® Canada, Inc. (the Company) to apply the amount to be reimbursed from this claim only to the payment of the next renewal premium for policy number _____.
I understand this authorization does not guarantee that my policy will be renewed on time. It is my responsibility under the policy terms to confirm that the reimbursements applied cover the totality of the premium due before the expiration of the grace period.
I understand that the renewal premium may vary due to a change of rate or due to any other change made to the coverage.
This authorization serves as a receipt of the reimbursement for the compensable claims made under my policy and it does not in any way invalidate the terms and conditions of the policy, particularly the "payment of the premium" and the "rate changes" provisions.
The company reserves the right to accept this request and to limit the amount of money to apply to future reimbursements.

I agree and give my consent for VUMI® Canada, Inc. and its subsidiaries and affiliates to send and obtain information regarding my health to/from an authorized medical team, hospitals, health clinics, public health authorities, insurers and similar institutions, in order to prove the veracity of this claim. This consent applies only for the illnesses, injuries and diagnoses indicated.
I declare that the information provided by me is true, complete and given in good faith. If any of the information disclosed here is false, incorrect, incomplete, had the intention of misleading or deceiving, or was omitted, I understand the policy will be canceled and the Company will not be responsible for any payments of the benefits offered under the plan. I agree to reimburse any payment made as a result of an omission, incorrect disclosure or negligence caused by me.

Signature of the insured: Date:

X _____ M M / D D / Y Y Y Y

VUMI® Canada, Inc.
Administration services provided by VUMI® Canada, Inc.

Address: 170 Attwell Drive, suite 690. Toronto, Ontario M9W-5Z5
Main Toll Free: +1.800.879.4236
infocanada@vumigroup.com • vumicanada.com