



MAIL TO: Group Operation  
400 – 200 Main Street, Winnipeg, MB R3C 1A8 1-800-665-7076

**Out of Country Claim Form**

**CLAIMING INSTRUCTIONS**

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| <p>1. <i>This form is used for reimbursement claims only.</i></p> <p>2. <i>This form is to be completed by the Plan Member.</i></p> <p>3. <i>All claims must be assessed by your government health insurance plan (GHIP) first.</i></p> | <p>4. <i>Please attach a copy of your statement of payment or denial from your GHIP.</i></p> <p>5. <i>The receipts/invoices will not be returned. Please keep copies for your records.</i></p> <p>6. <i>A fee will be charged for copies of claim documents.</i></p> |
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**EMPLOYEE STATEMENT**

Group Number: <b>G</b>	Employer Name: _____	Certificate Number: <b>WLI</b>
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Employee Name: \_\_\_\_\_

**Complete this section if this is your first claim or if your address has changed since your last claim. Our records will be updated.**

Home Address: \_\_\_\_\_

Street
City
Province
Postal Code

Are you, your spouse or dependents eligible for the claimed expenses under any of the following plans?

Spouse's employer/retiree plan:	<input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, provide insurance carrier name and policy number: _____
Credit Card(s):	<input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, provide insurance carrier name and policy number: _____
Travel Insurance:	<input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, provide insurance carrier name and policy number: _____
Home/Auto Insurance:	<input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, provide insurance carrier name and policy number: _____
Other (specify): _____	<input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, provide insurance carrier name and policy number: _____

**PATIENT INFORMATION**

Name: \_\_\_\_\_ Date of Birth: (YY/MM/DD) \_\_\_\_\_

Relationship to Employee: \_\_\_\_\_ Sex:  MALE  FEMALE

**CLAIM DETAILS**

1. Provide the reason for your out of country visit: \_\_\_\_\_
2. Provide the date of departure from your country of residence: \_\_\_\_\_ (YY/MM/DD)
3. Provide the date of return to your country of residence: \_\_\_\_\_ (YY/MM/DD)
4. Provide the date of accident/illness: \_\_\_\_\_ (YY/MM/DD)
5. Provide the location (city, country) of your accident/illness: \_\_\_\_\_
6. Provide diagnosis: \_\_\_\_\_

**Total Amount Claimed** \_\_\_\_\_ **Currency** \_\_\_\_\_

**EMPLOYEE AUTHORIZATION**

Notice Concerning Personal Information  
You have previously provided consent to Wawanesa Life for the collection, use and disclosure of your personal information for the purposes of: establishing and maintain communications with you; underwriting risks on a prudent basis; investigating and paying claims; detecting and preventing fraud; offering and providing products and services to meet your needs; compiling statistics and acting as required or authorized by law. That consent applied to personal information being provided to Wawanesa Life at that time and to personal information that may be provided after that time.

You can obtain further information about Wawanesa Life's Personal Information Protection Policy from the Wawanesa Life Head Office at 400 – 200 Main Street, Winnipeg, MB R3C 1A8 or at [www.wawanesalife.com](http://www.wawanesalife.com).

Authorization  
I have read the above Notice Concerning Personal Information. I authorize the release of any information in respect of this claim to Wawanesa Life. I further certify that the information on this form is true and complete.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

For Wawanesa Life Head Office Use Only