Manulife Financial

B.C. Colleges & Institutions

# Group Benefits
# Medical Travel Referral Expense

## SECTION 1 - TO BE COMPLETED BY PLAN MEMBER

**College of the Rockies** **83717**

**Plan Sponsor/Employer** Policy # Plan Member ID #

**Plan Member** – Last Name First Name and Initial Date of Birth (yyyy/mm/dd)

Plan Member – Address No. Street City Province Postal Code

1. Is this your first claim with Manulife Financial? ☐ No ☐ Yes
2. Are expenses related to a Workers' Compensation Claim? ☐ No ☐ Yes
3. Are expenses related to an automobile accident? ☐ No ☐ Yes
4. Are benefits payable from another group plan? ☐ No ☐ Yes
5. Are expenses related to a Dental Claim? ☐ No ☐ Yes

   (Dental related travel expenses are only eligible when referred by a licensed doctor (MD) and/or when hospitalization for dental treatment is required.)
6. Are you seeking damages from a third party? ☐ No ☐ Yes

   If "Yes," please provide name of the employer and other insurance company _____

## Expense Information

Family Member – Name Relationship Date of Birth (yyyy/mm/dd)

1. Is spouse/child employed? ☐ No ☐ Yes
2. If over age 16, is child in school? ☐ No ☐ Yes If "Yes," indicate name of employer or school _____

A spouse who is covered by another medical plan must first submit his/her claim to his/her insurer. Once that has been completed, please provide Manulife Financial with a completed claim form and a copy of the settlement provided by the other carrier. Claims for children must first be submitted to the insurer of the parent whose birthday occurs first in the calendar year. If spouse previously had coverage which is no longer active, please indicate the cancellation date

_____
Cancellation Date (yyyy/mm/dd)

| Date of Expense | Description (Transportation, Meals) | Charge | Name/Location of Treating Physician |
|---|---|---|---|
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**Coverage Limits:** $125/day – 50 days per year

**Meal Allowance:** Provide breakdown of expenses for breakfast, lunch and/or dinner for each individual and attendant (if required).

1. Indicate mileage travelled from HOME CAMPUS to locale where treatment is rendered _____ kms
2. Indicate mode of transportation ☐ Scheduled air ☐ Rail ☐ Bus ☐ Ferry ☐ Taxi ☐ Auto

   If by auto, indicate mileage travelled from place of residence to locale where treatment is rendered _____ kms
3. Was an attendant required to accompany patient? ☐ No ☐ Yes
4. Were overnight accommodations required? ☐ No ☐ Yes

   If "Yes," indicate type of facility (hotel/motel/Ronald McDonald House, etc.) _____

   Length of stay _____ (days)

**Please complete all requested information and attach original receipts to the claim form. Incomplete forms, or those without receipts cannot be processed for payment.**

## SECTION 2 - AUTHORIZATION FOR MEDICAL TRAVEL

**Referring Physician's Statement**
**Referral must be made by a licensed doctor (MD).**

**To be completed when medical travel is the result of a medical referral for service not available locally.**

1. Is this the first referral? ☐ No ☐ Yes

   If "Yes", attach referral or provide details. _____

2. Is this a revisit? ☐ No ☐ Yes

   If "Yes", provide the date of the last visit _____ (yyyy/mm/dd) . A new physician's referral is required if it has been more than one year since the last referral for this treatment.

   If required, attach referral or provide details. _____

3. Does the patient require an attendant while travelling? ☐ No ☐ Yes (An Attending Physician's request is required with each claim.)

   Please provide the reason it is medically necessary that the patient requires an attendant. _____

4. Please provide the reason the patient cannot be treated locally. _____

| **Referring Physician's Name** | Location |
|---|---|
| Signature | Date of Referral Treatment(s) (yyyy/mm/dd) |
| **Consulting Physician's Name** | Location |
| Signature | Date(s) Patient Seen (yyyy/mm/dd) |

## SECTION 3 - DECLARATION & AUTHORIZATION

**I certify** that I, my spouse and/or my dependants of minor or major age ("Dependants"), have received all goods or services claimed and that the information provided for this claim is true and complete. **I authorize** Manulife Financial ("Manulife") to collect, use, maintain and disclose personal information relevant to this claim ("Information") for the purposes of Group Benefits plan administration, audit and the assessment, investigation and management of this claim ("Purposes"). **I am authorized** by my Dependants to disclose and receive their Information, for the Purposes. **I authorize** any person or organization with Information, including any medical and health professionals, facilities or providers, professional regulatory bodies, any employer, group plan administrator, insurer, investigative agency, and any administrators of other benefits programs to collect, use, maintain and exchange this information with each other and with Manulife, its reinsurers and/or its service providers, for the Purposes. **I authorize** the use of my Social Insurance Number ("SIN") for the purposes of identification and administration, if my SIN is used as my plan member certificate number. **I agree** a photocopy or electronic version of this authorization is valid. **I understand** that Manulife's Privacy Policy and Privacy Information Package are available at www.manulife.ca/groupbenefits, or from my Plan Sponsor.

Any Information provided to or collected by Manulife in accordance with this authorization, will be kept in a Group Benefits health file.
Access to your Information will be limited to:

- Manulife employees, representatives, reinsurers, and service providers in the performance of their jobs;
- Persons to whom you have granted access; and
- Persons authorized by law.

You have the right to request access to the personal information in your file, and, where appropriate, to have any inaccurate information corrected.

**You must sign and date in the space provided below. Failure to sign the claim will result in your claim being returned for signature.**

**Plan Member's Signature:** _____ **Date:** _____

IF YOU HAVE QUESTIONS,
CALL YOUR B.C. COLLEGES & INSTITUTIONS BENEFIT HELPLINE AT 1 800 575 2200.

Manulife Financial
Group Benefits - Health Claims
PO BOX 1653
WATERLOO ON N2J 4W1