Arch Insurance Canada Ltd.
Medical Expense Claim Form

Claims Department: Executive Plaza IV, 11350 McCormick Road, Suite 102, Hunt Valley, MD 21031
Phone No: 1-844-800-2486 | **Fax:** 1-443-279-2901 | **Email:** redsky@archinsurance.com

Medical Expense Claim Instructions

Please complete and sign the Medical Expense claim form in full and return it with the documentation noted below.

Your claim should be submitted to the address at the top of these instructions.

For all claims, submit:

- Copy of your original travel itinerary
- Proof of all claimed expenses
- Copies of medical records of your condition and treatment; copies of invoices or receipts for all claimed medical expenses. Invoices should show the date of service, the office or facility where the service was provided, the condition treated and the nature of the treatment received.
- Proof of payment of the claimed medical expenses
- Proof of loss:
    - Medical records or other documentation showing the nature of the condition and the treatment received;

If your policy provides excess medical insurance coverage, only medical expenses not covered under any other insurance plan (including expenses covered under a provincial or territorial health insurance plan) will be covered. You must first file your claim under that other insurance plan before you may file a claim with us for unpaid medical expenses. Your Medical Expense claim should be supported by copies from your other insurance plan showing claim amount marked as your responsibility, including reason for non-coverage.

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Section 1 - Claiming Benefits

To be Completed by Insured Claiming Benefits

Name of Claimant / Insured	Policy No.	Phone No. ( )
Address		Date of Birth
Email Address		
Travelling Companion(s)	Relationship	Trip Departure Date / Trip Return Date
Initial Trip Deposit Date		
Date Incident Occurred		

Travel Supplier / Tour Operator / Cruiseline

Do you have other medical insurance that may provide coverage for this claim? Yes ☐ No ☐

If so, has a claim been submitted to the other company? Yes ☐ No ☐

Name address and phone number of the other insurance company

Primary Insurance Carrier	Policy No.
Secondary Insurance Carrier	Policy No.
Date injury occurred or symptoms began	Date first treated for this illness or injury
Explain when and where injury occurred or illness began	Describe nature and diagnosis of illness or injury

Name, address and phone number of physician who first treated you for this condition

If hospitalized, name and address of the hospital

Was an accident or police report filed? Yes ☐ No ☐ If yes, please provide a copy.

Had you ever been treated for this condition before? Yes ☐ No ☐ If so, when?

Name, address and phone number of physician who previously treated this condition:

Arch Red Sky℠

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Section 2 - Claimed Expenses

Please list all medical expenses incurred as a result of this sickness or injury. Enclose copies of medical bills, reports and explanations of benefits from your Primary and Supplemental insurance companies.

Claimed Expenses

Name of Provider	Date of Service	Type of Service	Amount of Bill	Amount paid by other Insurance	Amount Claimed
		Totals	0.00	0.00	0.00

Any person who knowingly and with intent to injure, defraud or deceive any insurance company, files a statement claim containing any false, incomplete, or misleading information may be guilty of a criminal act punishable by law.

I have read the foregoing, and the above answers are true and complete according to the best of my knowledge and belief.

Signature of Claimant **Date**

Authorization to Disclose Information

To any medical care provider, medical care facility, insurer, government-sponsored health plan, or employer: I authorize the release of any medical information about me to Arch Insurance Canada Ltd., (the "Company"); or it's authorized representative. This applies to all information about the diagnosis, treatment, or prognosis of any illness or injury I now have or have had in the past.

To any insurance company, any travel organization or agency, airline carrier, cruise line, your operator, rental agency, hotel, motel, or similar entity providing lodging on a rental / lease basis or any other person who may have knowledge regarding this claim: I authorize the release of any information requested regarding this claim and the loss reported.

The Company will use this information to determine if any claim is eligible. Any information obtained will not be released by the Company except to my primary health insurance carrier (if any) or persons or organizations performing investigation or legal services for the Company in connection with my claim. A copy of this authorization shall be considered as effective and valid as the original and shall remain in effect for one year from the date of authorization.

I certify that the information given by me in support of my claim is true and correct. I understand that any person who knowingly and with intent to defraud or deceive any insurance company files a claim containing any materially false, incomplete or misleading information may be subject to prosecution or insurance fraud.

_____ _____

Claimant or Authorized Representative's Signature **Date**

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If Authorized Representative, Relationship to Claimant