beneva

Claim form
Emergency medical care
Out-of-province or abroad

Instructions

Complete the form

1. Attach original invoices, payment receipts and any pertinent medical reports to the form. They will not be returned.
2. Attach a void cheque if you would like the benefits to be deposited in a Canadian bank account.

Submit the form

1. By email: travel.claims.sp@beneva.ca
2. By fax: 1 855 690-9895
3. By mail: Specialized Products, 1225 rue Saint-Charles Ouest, bureau 200, Longueuil QC J4K 0B9

Customer service

1. 1 855 395-2520 (voicemail)
2. By email: travel.claims.sp@beneva.ca

1. Plan member's information

Certificate No. | Policy/Group No. | Email

Last name | First name | Date of birth (Y Y Y Y M M D D) | Sex at birth: ☐ F ☐ M

Address

City | Province | Postal code | Telephone

Employment status: ☐ Active ☐ Retired

2. Information about the person concerned by the claim, if applicable
(one form per insured)

Last name | First name | Date of birth (Y Y Y Y M M D D) | Sex at birth: ☐ F ☐ M

Relationship to the plan member: ☐ Spouse ☐ Dependent child

Does the person live at the same address as the plan member? ☐ Yes ☐ No

Is the person a full-time university or CEGEP student? ☐ Yes ☐ No

3. Other health insurance coverage

Private plan Are you or your family members covered under another private health insurance plan? ☐ Yes ☐ No

If so → Name of insurer: _____

Provincial plan Are you or your family members covered under a provincial health insurance plan? ☐ Yes ☐ No

If so → Provincial plan identification number: _____

4. Information about the claim – Illness

Date the symptoms appeared: (Y Y Y Y M M D D)

Diagnosis: _____

Briefly and clearly describe the symptoms that necessitated medical care. _____

Beneva Inc.
C.P. 11051 succ. Sainte-Foy, Québec QC G1V 0K1
1 888 235-0606

COL-F0670A (2024-09)

Have you ever experienced this illness or similar problems in the past? ☐ Yes ☐ No

If so → Date: Y Y Y Y M M D D

Provide details: _____

_____

_____

Were you hospitalized for this health condition? ☐ Yes ☐ No

If so → Name and address of the hospital: _____

_____

Hospitalization dates: Y Y Y Y M M D D to Y Y Y Y M M D D

5. Information about the claim – Injury following accident

Date of the accident: Y Y Y Y M M D D

Type of accident: ☐ Motor vehicle ☐ Work related injury ☐ Other, specify: _____

Briefly and clearly describe the accident. _____

_____

_____

6. Information about your trip

Departure date from province: Y Y Y Y M M D D Return date: Y Y Y Y M M D D

City and country where medical care was received: _____

Reason for travel: ☐ Vacation ☐ Work ☐ Education ☐ Other, specify: _____

7. Your family physician's information

Last name _____ First name _____ Telephone _____

Name of medical facility (ex: hospital, clinic, doctor's office): _____

Address: _____

8. List of expenses claimed

Service date	Patient's name	Care or services claimed	Service provider's name	Amount claimed	Country and currency	Amount paid by another plan, if applicable
Y Y Y Y M M D D						
Y Y Y Y M M D D						
Y Y Y Y M M D D						
Y Y Y Y M M D D						
Y Y Y Y M M D D						
Y Y Y Y M M D D						
Y Y Y Y M M D D						
Y Y Y Y M M D D						

9. Protection of personal information

Protecting your personal information is a priority for Beneva. To find out more about our practices, please consult the Privacy statement located at beneva.ca.

10. Declaration

I consent to Beneva Inc. collecting, using and disclosing any personal information that is necessary for managing my claim. This information may be disclosed to any group insurance policyholder, healthcare professional or intervening party in the health field as well as any service provider (travel assistance service, IT services, etc.) I declare that the information provided is true, accurate and complete to the best of my knowledge. I am authorized by my spouse and my dependents impacted by this form to disclose and receive information regarding them.

X _____ Y Y Y Y M M D D

Signature Date