Schedule A

CUMIS®

Allianz

Global Assistance

Allianz Global Assistance Claims Department
250 Yonge Street, Suite 2100
Toronto, Ontario M5B 2L7
Canada
Collect worldwide: 416-340-8809
Toll-free Canada/U.S.A.: 1-800-869-6747

ASSIGNMENT OF PAYMENT DUE TO INSURED PERSON OR BENEFICIARY UNDER THE SASKATCHEWAN MEDICAL CARE INSURANCE ACT OR THE SASKATCHEWAN HOSPITALIZATION ACT

BETWEEN: _____ of the first part,
(claimant's name) _____ hereinafter referred
_____ to as the Assignor

AND: AZGA Service Canada Inc. of the second part,
o/a Allianz Global Assistance hereinafter referred
to as the Assignee

AND: HER MAJESTY THE QUEEN IN THE RIGHT
OF THE PROVINCE OF SASKATCHEWAN AS hereinafter referred
REPRESENTED BY THE MINISTER OF HEALTH to as the Minister

WHEREAS the Assignor is a person eligible for medical services under The Saskatchewan Medical Care Insurance Act or The Saskatchewan Hospitalization Act or both, and as such may receive payment for the above services from the Minister.

AND WHEREAS the Assignor is under a covenant or obligation under a contract with the Assignee to remit to the Assignee all such payments received for medical services from the Minister.

NOW WITNESS THAT in consideration of the said obligation to the Assignee the Assignor hereby assigns unto the Assignee all sums of money that shall be owing to the Assignor by the Minister for the above noted contract. The Minister is hereby authorized to pay all such sums directly to the Assignee at the aforesaid, or at any address the Assignee may from time to time designate, with payment of any such sum to be sufficient discharge to the Minister of and from any indebtedness in that amount to the Assignor, his heirs, executors, or administrators.

DATED this _____ day of _____, 20 _____

_____
Signature of Assignor (Insured)
(parent/guardian if minor)

WITNESS:

Signature _____

Occupation _____

ASSIGNMENT:

Effective from: _____/_____/_____ (DD/MM/YY)

To: _____/_____/_____ (DD/MM/YY)

Schedule B

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AUTHORIZATION TO PROVIDE MEDICAL INFORMATION

I, _____ (or I, _____

parent/guardian of _____ , a minor) hereby consent to and authorize the Department of Health to furnish to any representative of AZGA Service Canada Inc.o/a Allianz Global Assistance claim and payment information in the Department of Health's possession in respect of claims for Medical Services incurred while I had insurance coverage from _____ (DD/MM/YY) to _____ (DD/MM/YY) and may include payment and claim information for the period within 6 months prior to the date of service of the aforementioned Medical Services including physician/hospital name, date of service, and service provided (in-patient, out-patient, physiotherapy, visit, procedure, x-ray or laboratory service).

DATED this _____ day of _____ , 20 _____

Health Services Number _____ Signature _____

Address _____

Telephone _____