In-Canada Claim Form



INSTRUCTIONS

IMPORTANT

- Please note that if your total claim amount does not exceed \$500 (CAD), a completed claim form is not necessary. Simply submit your receipts, invoices, and any supporting documentation, along with your name, policy number and full mailing address, via email to studentclaims@studyinsured.com.
- *NEW: Ensure payment information in Section F is complete and accurate.
- All claims must be reported to StudyInsured™ Assistance within 30 days of occurrence.
- Written proof of claim must be submitted to StudyInsured™ Assistance within 90 days of occurrence.
- You are responsible for all fees charged for any supporting documentation.
- · Failure to complete and sign this form in its entirety or submit supporting documentation will delay claim processing.

CLAIMS SUBMISSION

- Complete all sections and ensure this form is signed before submitting to StudyInsured™ Assistance with all invoices, physician and medical reports detailing treatment and treatment dates, and prescription pharmacy receipts. Keep copies for your records.
- · Claimants must attach a copy of the emergency room report and all hospital records if treatment was received at a hospital.

DISCLAIMED

• StudyInsured™ Assistance reserves the right to request that a claim form be completed, regardless of the amount being claimed

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NOOKED	, FER.	JON												
Last Na	me	9					rst Name			Date of Birth	(DD/MM/YYYY)			
	☐ Male ☐ Female ☐ Non-binary ☐ Undisclosed						roc marrio				Date of Birth (BB/MM/1111)			
⊔ Ma	Tale Female Non-binary Undisclosed Country of Origin C									Arrival Date in Canada (DD/MM/YYYY)				
							•							
Policy N	Policy Number Group Number ID Number					Ec	ducationa	l Institution			Enrollment Date (DD/MM/YYYY)			
NSURED	PER	SON'S ADI	DRESS	IN CANA	DA									
Unit #	9	Street Name	and #						Cit	у		Province	Postal Code	
Telepho				Mobile			Email							
LAIMAN	IT (IF	DIFFEREN	NT FRO	M INSUR	ED PERSON)									
First Na	me		Last Name					Relationship	to Insured					
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Unit #	Stree	et Name and	1 #	T		City	Τ			State/Province	Country		ZIP/Postal Code	
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Full Nar	ne							Clinic Name	or Pra	actice				
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Unit #	Stree	et Name and	l #			City				State/Province	Country		ZIP/Postal Code	
Telepho	ne			Fax										
NSURED	PER	SON'S FAI	MILY PH	IYSICIAN	IN COUNTRY OF	ORIGI	N (IF AV	AILABLE)						
Full Nar	Full Name					Clinic Name or Practice								
Unit #	Stree	et Name and	#	1		City				State/Province	Country		ZIP/Postal Code	
T. I				F										
Telepho				Fax			l							
SI	ECT	ION B:	отн	ER IN	SURANCE	COVE	ERAG	E						
Does th	ie insu	red persor	n curren	itly have	provincial or gove	ernment	covera	ge of any kin	d?	☐ Yes ☐ No				
IF YES, provide the name of the provincial or government agency providing coverage:														
L														
Is the ir	nsured	person co	overed b	y anothe	r medical or trav	el insura	ance pol	icy (includin	g co	verage through a	spouse, parent, o	r guardian?)	Yes No	
IF YES,	provid	le details d	of other	insuranc	e coverage:									
Full Name of Policyholder							Insurance Company							
									L					
Policy/Plan Number			I	ID/Certificate Number Employer Grou (if applicable)			Number	Emp (if a	oloyer Name pplicable)		Employer Phone (if applicable)			

SECTION C: CLAIM INFORMATION											
Description of insured's sickness or injury (if this space is insufficient, additional information can be attached):											
Date symptoms first appeared	or injury occurred (DD/MM/YY):	:									
Has the insured person ever be	een treated for this, or a similar	or related, con	dition before?	□ Yes □ No							
Date insured first saw a physician for this, or a similar or related, condition (DD/MM/YY):											
Please provide all dates of treatn	nent and list all medications take	n for this, or a si	milar or related, o	condition before the effective dat	e of the policy:						
Treatn	nent Date (DD/MM/YY)			Medication							
SECTION D. EXP	ENSES CLAIMED										
SECTION D. EXT	ENSES CERTIFIED										
Name of Medical Provider	Reason for visiting the doctor & Diagnosis		Service MM/YY)	Amount Billed (\$)	Amount Paid (\$)						
		,	. ,								
SECTION E: AUTHORIZATION AND CERTIFICATION											
Certain Lloyd's Underwriters ("Lloyd's"), StudyInsured" Assistance ("StudyInsured"), its agents, and administrators, are obliged to collect and retain certain personal and/or health											
nformation about you in connection w	ith your insurance coverage. We use a	and disclose this i	nformation only for	the purposes of administering your I	policy/policies of insurance,						
oroviding customer service, and in assessing and paying claims. We are committed to protecting the privacy, confidentiality, and security of the personal information we collect, use, retain, and disclose. Your personal information will be used only for the purposes of providing you with the requested insurance services. Lloyd's and StudyInsured's complete privacy policies are evaluable upon request.											
authorize any doctor, medical practitioner, hospital, facility providing medical or health-related services, third-party administrator, provincial plan, and any other insurer to release											
and exchange with Lloyd's, Studylnsured, or its representatives, any information (including personal health data and records) required to process this claim. I authorize any third party providing me with assistance in this claim process to have access to any and all relevant claims information related to the adjudication of my claim with Lloyd's and Studylnsured.											
authorize StudyInsured to coordinate the payment of benefits with any insurance carriers that may have a liability for this claim and assign to Lloyd's and StudyInsured any benefits bayable from any other sources for losses covered under this policy, and authorize and direct such payers to forward payment directly to Lloyd's and StudyInsured. I confirm below											
ry my signature that I am authorized to act on behalf of any of my dependants for these purposes. A photocopy of this authorization shall be as valid as the original.											
certify that the information provided	in connection with this claim is con	nplete, true, and a	ccurate.								
Name of Insured (please print)											
If Insured is under age 16, full name of parent/legal guardian (please print)											
Signature of Insured (if under age 16, signature of parent or legal guardian) Signature of policyholder of other insurance in Section B, if applicable											
SECTION F: AUTHORIZATION TO PAY											
	HURIZATION TO PA	Υ									
THIS CLAIM IS PAYABLE TO:											
☐ Insured at the address in Section A above ☐ Parent/Guardian ☐ Hospital/Clinic ☐ Physician											
Other: If applicable, I authorize payment of this claim to (please print): PAYMENT METHOD											
☐ Cheque ☐ Sidekick (Prepaid VISA) ☐ Electronic Funds Transfer (For EFT payments, complete fields below and check for accuracy)											
Account Holder Name	Financial Insti	itution Number	Transit Number	Account Number							
Date signed (DD/MM/YY):											