

Claim Form - International Student Sickness & Accident Insurance

Important notes: Incomplete forms will be returned and will delay processing of your claim. All sections must be completed in full.

- Any fee for the completion of this form is to be paid by the claimant.
- Please submit original receipts
- Attach a photocopy of the insurance enrollment card or student ID card

Claimant Information (to be completed by patient/claimant)

Claim No.

School Name		Date of Arrival in Canada (Y/M/D)	
Group No. FS	Date of Birth (Y/M/D)		
Student I.D. No.	<input type="checkbox"/> Male <input type="checkbox"/> Female		
Insured's First Name	Surname/Family Name		
Address in Canada	City	Prov.	Postal Code
Telephone	Email		

Do you have any Medical/Hospital coverage other than T.I.C. Travel Insurance Coordinators? Yes No
 If Yes, please provide name and address of insurance company Policy No.

Name of Patient (if different than insured person named above) Date of Birth (Y/M/D)

Diagnosis or nature of illness (please explain briefly what happened)

Have you ever been treated for this or a similar sickness before? Yes No

If Yes, please indicate dates of all treatment for this condition and medication prescribed at that time

Name and address of physician who treated you for this condition in the past

If due to injuries, briefly describe how the accident happened

If due to a motor vehicle accident, has Auto Plan insurance been notified? Yes No

Give details such as name and address of other insurance company and name of adjuster

Authorization and Certification (to be completed by patient/claimant)

I authorize any doctor, Hospital or facility providing medical or health related services, my Provincial Health Plan or any other Insurer providing similar health benefits to release to and exchange with T.I.C. Agencies Ltd., or its representatives any information that the Insurer requires to process this claim, and I assign to T.I.C. Agencies Ltd. any benefits obtainable and recoverable from other sources for losses covered under this policy.

I further authorize insurers providing similar benefits to forward payment directly to T.I.C. Agencies Ltd. for claims submitted by T.I.C. Agencies Ltd.

A photocopy of this Authorization shall be considered valid.

I certify that the information provided in connection with this claim is correct and true to the best of my knowledge and belief.

Date (Y/M/D)	Full name of patient
I authorize payment of this claim either to: <input type="checkbox"/> the supplier of service <input type="checkbox"/> the person named here: (print name)	Insured's/Patient's signature (if minor, signature of parent or legal guardian)

Privacy Protection

T.I.C. is dedicated to protecting your privacy. Your medical information is collected solely for the purpose related to the determination of liability under the insurance policy to adjudicate your claim. Once the information is collected and used it is kept in secure storage for a period of time as required by law. For a copy of T.I.C.'s complete privacy policy please contact us or visit our website at www.travelinsurance.ca

Physician's Billing (to be completed by physician)

Date of service (Y/M/D)

Amount charged

Is patient being referred for x-ray, lab work? Yes NoHas patient been given a prescription? Yes No If Yes, please attach a copy of your prescription request

Attending Physician's Statement (to be completed by physician)

Name of patient

Date of Birth (Y/M/D)

Diagnosis (or cause of death)

Date symptoms first appeared (Y/M/D)

Date you were first consulted (Y/M/D)

Date condition first diagnosed (Y/M/D)

Is this a new condition? Yes No

Please describe the patient's history of this condition and any other related conditions during the past 12 months prior to this visit.

a) include dates of all medical visits

b) diagnosis, and

c) treatments rendered

Was this condition:

 related to the use of alcohol, misuse of drugs, or self-inflicted injury? related to pregnancy? due to an accident?

Was patient hospitalized? If Yes, name of hospital

 Yes No

Date of admission (Y/M/D)

Date of discharge (Y/M/D)

Is patient on medication for this condition or any other condition? Yes No

If Yes, give details

In your medical opinion, would the patient have been medically fit to travel after the initial diagnosis and/or emergency treatment? Yes No

If No, why and on what date would the patient have been fit to travel (Y/M/D)

Please use this space for any additional information or comments

Physician's Certification and Signature

I certify that the information provided in this section is correct and true to the best of my knowledge and belief.

Physician's signature

Physician's name (please print)

Date (Y/M/D)

Mailing address

City

Telephone ()

Province/State

Country

Postal Code

Physician's stamp