Student Claim Form

1 POLICY INFORMATION

Policy Number	Effective Date (dd/mm/yy)	Expiry Date (dd/mm/yy)	Student Name Last Name / First Name

☐ Male ☐ Female	Date of Birth (dd/mm/yy)	Full Canadian Address Street / City

Province / Postal Code	Phone Number	Email Address

2 DETAILS OF MEDICAL VISIT

Name of Provider	Reason for Medical Care (Diagnosis)	Date of Service (dd/mm/yy)	Fees Billed ($CAD)	Amount Paid ($CAD)

FOR DIRECT BILLING BY MEDICAL PROVIDERS ONLY

☐ Lab Work Ordered ☐ X-Ray Ordered ☐ Prescription Given ☐ Other/Details: ______________________

1) Does this constitute emergency treatment required to treat an acute, unexpected illness or injury? ☐ YES ☐ NO

OR 2) Was this treatment scheduled or provided for the ongoing maintenance of a chronic illness/condition? ☐ YES ☐ NO

3) Has the same or a similar condition/illness occurred in the 90 days prior to the Effective Date of Coverage? ☐ YES ☐ NO

if Yes, please provide details): ______________________

If the answer to 1) is YES, please submit for direct reimbursement.
If the answer to 2) or 3) is YES, please have the insured pay for the treatment and claim independently.

I DECLARE THAT THE ABOVE IS A CORRECT STATEMENT OF SERVICES PERSONALLY RENDERED BY ME.

MD's Name	MD's Signature	Phone Number	Dated (dd/mm/yy)
	X		

3 ASSIGNMENT OF BENEFITS

Cheque Should be Payable To: ☐ Claimant **OR** ☐ Other (Indicate below)

Name Last Name / First Name	Phone Number

Address Street	City	Province	Postal Code

I, the undersigned, declare that all the information provided in this claim form is true and complete. I authorize the sharing and disclosure of information related to my claim or my medical history among or between any of the following entities: the attending physician, any medical facilities, my physician in my home country, my educational institution, Ingle International and Imagine Financial Ltd, the insurer administering or underwriting this policy and the claims management group or assistance company appointed by the insurer. I understand that if my medical records are not released to the insurer, benefits may not be payable. I agree that a reproduction of this claim form is as valid as the original. I assign to the insurer any benefits related to this claim which would be payable to me from any other source and authorize the insurer to collect any such benefits on my behalf.

Claimant's Signature	Date (dd/mm/yy)
X	

4 PLEASE RETURN COMPLETED FORM TO:

Ingle International - Claims Administration
460 Richmond Street West, Suite 100
Toronto, Ontario (Canada) M5V 1Y1
Phone: (416) 640-7863
Toll free: 1-800-360-3234
Fax: (416) 730-1878
Email: studentclaims@ingleinsurance.com