Global Assistance

Allianz

Allianz Global Assistance Claims Department
2100 – 250 Yonge Street,
Toronto, Ontario, Canada
M5B 2L7

INTERNATIONAL STUDENTS CLAIM FORM

IMPORTANT: You must complete all sections of the form so the evaluation of the claim can proceed without delay. It may be returned to you if the information is incomplete or incorrect.

Policy #:

Certificate or Student #:

SECTION A – PRIVACY AND DECLARATION

Allianz Global Assistance Privacy Statement

Allianz Global Assistance is committed to protecting the privacy, confidentiality, accuracy and security of the personal information that it collects, uses, retains and discloses in the course of conducting business.

At Allianz Global Assistance, we recognize and respect the importance of privacy. When you enrol for insurance coverage or submit a claim, we establish a confidential file and collect, use and disclose your personal information1 for the purposes of issuing, administering, adjudicating and/or servicing your insurance. You may access and correct, if needed, the personal information in your file by sending us a request in writing.

We limit access to your personal information to our staff and other persons we have authorized who have a need to know it to perform their duties. Our systems and procedures are designed to prevent the loss, misuse, unauthorized access, disclosure, alteration, or destruction of your information. Our commitment to security extends to the contracts and agreements we sign with external suppliers and service providers. We may store or process your personal information in Canada, the United States or other countries for processing, storage, analysis or disaster recovery and, under applicable law, governments, courts, law enforcement or regulatory agencies, may, by lawful order, obtain disclosure of your personal information. You can find more details about Allianz Global Assistance's privacy policy at www.allianz-assistance.ca. If you have any questions regarding our privacypractices, please contact the Privacy Officer at :

AZGA Service Canada Inc.
o/a Allianz Global Assistance
250 Yonge Street, Suite 2100
Toronto, Ontario M5B 2L7
Canada

Telephone: 416-340-1980
E-Mail: privacy@allianz-assistance.ca

If you do not agree with our use and disclosure of your information in connection with your application and servicing any policy that we issue, we will not be able to offer you the insurance product you are interested in, service your insurance or adjudicate your claim.

I have read and understood the privacy statement and I consent to the collection, use, retention and disclosure of my personal information or those of my dependants for the purposes stated above. I understand that I may revoke my consent at any time in writing and acknowledge that should I do so, my claim may not be adjudicated.

I hereby assign to AZGA Service Canada Inc. o/a Allianz Global Assistance any benefits obtainable from other sources for losses covered under this policy. I authorize and direct these sources to release payments to Allianz Global Assistance and for Allianz Global Assistance to release pertinent payments to other parties for the purposes of processing my claim.

I certify that the information contained herein is true, complete and accurate and that each of the listed expenses was purchased and/or incurred in connection with the medical treatment of the individual(s) named below. I acknowledge that the submission of false or incomplete information may result in the delay or denial of this claim. In the event there is suspicion and/or evidence of fraud and/or plan abuse concerning this claim, I acknowledge and agree that Allianz Global Assistance may investigate any information about me, my spouse and/or dependents pertaining to this claim, which may be used and disclosed to any relevant Third Party, and where applicable my plan sponsor, for the purpose of investigating and preventing fraud and/or plan abuse.

If I receive payment from Allianz Global Assistance in an amount that exceeds the benefit(s) to which I am entitled under the policy (the "overpayment amount"), then I acknowledge and agree that: (a) I am indebted to Allianz Global Assistance for such overpayment; (b) Allianz Global Assistance has the right to recover the overpayment amount through any means available by law; and (c) Allianz Global Assistance will offset any benefits payable to me by the overpayment amount until Allianz Global Assistance has recovered the overpayment amount in full.

I declare my statements above, including all other past and future statements made through personal or telephone interviews relating to my claim, to be true, complete, current and accurate.

Insured's Signature: Date (M/D/Y):

Insured's Name (please print): Policy #:

IMPORTANT INFORMATION ON THE BACK — PLEASE COMPLETE THE OTHER SIDE OF THIS FORM ⇨

SECTION B – TO BE COMPLETED BY INSURED

Last Name: First Name:

Date of Birth (M/D/Y): Phone Number: E-mail:

Address – # and Street: Apt.:

City: Province: Postal Code:

Do you have health benefits or services provided under any other health plan (including Government Health Insurance Plan)? ❑ Yes ❑ No

Name of the insurance company: Policy or Certificate #:

Is this reimbursement request the result of an accident? ❑ Yes ❑ No If Yes, please provide details (date, type, circumstances):

SECTION C – INFORMATION ON EXPENSES INCURRED

In the case of a PREGNANCY, indicate the date of last menstrual cycle (M/D/Y): _____

Date (M/D/Y)	**Diagnosis** (why you consulted) and **Description of Services** (e.g. Doctor's visit, physiotherapy, prescription drug, etc.)	**Charges / Fees**
		$
		$
		$

This claim is payable to: ❑ Insured member at the above address ❑ Physician ❑ Clinic/Hospital ❑ Parent/Guardian ❑ Other

If payable to the physician, clinic/hospital, parent/guardian or another person, please indicate Name:

Address – # and Street: Apt:

City: Province: Postal Code:

Phone Number: Fax: E-mail:

Physician's signature:	Patient's signature:
(Only required if physician submits for direct reimbursement from Allianz Global Assistance. See instructions on the back)	(Required to authorize reimbursement to an individual other than the insured.)

SECTION D – DIRECTION AND AUTHORIZATION TO PHYSICIANS, HOSPITALS AND OTHER MEDICAL PROVIDERS

By signing this form, I hereby authorize and direct any physician, health care facility, treatment provider, plan administrator, any insurance company, reinsurer, provincial health insurance plan, government department (collectively, "Third Party") having medical or other relevant personal information[1] regarding me, my spouse and/or dependent to disclose, release, share and exchange information with Allianz Global Assistance, its underwriter, plan administrator, agent or representative any and all such information necessary for the purposes of determining my eligibility, assessing my application, investigating and confirming the accuracy and validity of my claim, and administering or processing my claim. I am authorized to act on behalf of my dependants for these purposes. The authorization and direction I provided herein shall be good and sufficient authority, and any copy of this completed form is as valid as the original. My consent and authorization shall remain valid for the duration of my claim unless I revoke these in writing.

Full Name of Patient/Insured (please print): Date (M/D/Y):

I authorize payment of this claim to (print name):

Signature of Insured (if minor, signature of parent or legal guardian):

Signature of policyholder of other insurance in Section B (if applicable):

[1] IMPORTANT: Personal information excludes genetic tests. Genetic test means a test that analyzes DNA, RNA or chromosomes for purposes such as the prediction of disease or vertical transmission risks, or monitoring, diagnosis or prognosis.

OFFICE USE ONLY	Cheque #:	Date (M/D/Y):	Claim #:

IMPORTANT INFORMATION ON THE NEXT PAGE — PLEASE COMPLETE THE NEXT PAGE OF THIS FORM ⇨

SECTION E – TO BE COMPLETED IF COSTS WERE INCURRED DURING A TEMPORARY TRIP

❑ Outside your province or territory of residence ❑ Outside Canada

(Please consult your policy, in the Insurance Agreement Section to know if you should complete this section for the costs incurred.)

Reason for trip: ❑ Vacations ❑ Country of permanent residence ❑ Other, please specify: _____

* If the stay is for academic purposes, please provide a letter stating that the academic purposes are recognized by your institution.

Date of departure (M/D/Y): _____ Date of return (M/D/Y): _____

Please include a proof of travel dates (e.g. copy of passport, airline tickets, gas receipt).

Medical services received – Please indicate the reason you received medical treatment (diagnosis, nature of sickness or injury):

Describe the medical treatment received (e.g. consultations, diagnostic services, surgery, etc.). If space is insufficient, please attach another sheet of paper.

In what city and country were the services received:

If this claim is related to an accident, please provide details (date, type, circumstances):

Claimed Amount: $ _____ ❑ Canadian ❑ Other, please specifiy: _____ You will be reimbursed in Canadian currency, at the exchange rate on the date you are reimbursed.	Have the bills been paid? ❑ Yes ❑ No ❑ In full ❑ In part: $ _____

IMPORTANT INFORMATION

- Send only originals of all bills or receipts (copies are not acceptable). Originals will not be returned to you. As such, please conserve copies for your files.
- All claim forms must be signed by the insured person.

PRESCRIPTION DRUGS

- When you submit a claim form for prescription drugs, please attach the original receipts to the claim form.
- Receipts for medications must clearly indicate the name of the prescribing doctor, the identification number of the medication (DIN), the name of the medication, the date, the quantity and the total cost.

HEALTH PRACTITIONERS (physiotherapist, chiropractor, etc.)

Please attach a detailed note or a receipt which indicates the following information:

- Name of the patient
- Name of the
- License or registration number
- Health practitioner category
- Diagnosis
- Date(s) of the visit(s)
- Cost per treatment

MEDICAL APPLIANCES

If the terms and conditions of your policy require it (consult your policy to confirm), please provide the written recommendation of your treating physician for all prescribed appliances or equipment, including the diagnosis.

Please indicate the length of time that this equipment or medical appliance must be utilized, from:

(M/D/Y): _____ to (M/D/Y): _____

Send your claim form and your original bills or receipts to:

Allianz Global Assistance Claims Department

2100 – 250 Yonge Street,
Toronto, Ontario, Canada
M5B 2L7

DIRECT BILLING – NOTE TO THE PROVIDER OF MEDICAL SERVICES

To bill Allianz Global Assistance directly, you can fax this claim form, under the condition that it is completed and signed by both the physician and the insured.

Fax: 416-340-7152

FOR COMPANY USE ONLY	Fraud Verification A:	Fraud Verification B:

Travel insurance is underwritten by CUMIS General Insurance Company, with claims administration and emergency assistance provided by Allianz Global Assistance, formerly known as SelectCare. Allianz Global Assistance is a registered business name of AZGA Service Canada Inc.