

Discover the peace of mind that comes from knowing you're truly protected.

PLEASE PRINT CLEARLY

| | |
|-------------------------------------|-----------------------------|
| STUDENTGUARD® Policy Number: | Coverage Start Date: |
| Organization or School Name: | Coverage End Date: |
| Name of Insured/Patient: | Date of Birth: |

Who do we pay: _____ And How: Cheque (Make cheque payable to): _____

Name _____

Address _____

Tel: _____ **Fax:** _____ **Email:** _____

1. Do you have any other insurance? You must answer NO or YES (Include ANY other insurance.) If YES, provide details: _____

2. Were you hurt in an accident? NO or YES Tell us what happened, including when and where the accident happened: _____

3. Tell us WHEN and WHY you saw the doctor (below). *Original bills and receipts must be sent with this Claim Form for us to pay you.*

| Date (d/m/y) | Cost/Currency | Why you needed medical care (Diagnosis) |
|--------------|---------------|---|
| | | |
| | | |
| | | |

FOR DIRECT BILLING BY MEDICAL PROVIDERS ONLY

For prompt reimbursement as detailed below, FAX this signed form to **STUDENTGUARD®**

Rx given X-ray Ordered Lab work Ordered Other/Details

A) Is this emergency treatment, medically necessary to identify and/or treat an acute, unexpected sickness? NO or YES

OR B) Is this treatment pre-arranged and/or given to maintain the stability of a chronic sickness or condition? NO or YES

AND C) Did the same or similar conditions occur in the 90 days prior to the Coverage Start Date? NO or YES

If YES, provide details and dates: _____

If you answer YES to A) we will reimburse you directly.

If you answer YES to B) or C), have the insured pay for this visit. Questions? Please call the number below.

Medical Provider's Name **PRINT** _____ Date _____ Medical Provider's Signature (**only required for direct payment**) _____

ATTACH ALL BILLS and MAIL TO:

STUDENTGUARD® Claims
300 John Street, Suite 610
Thornhill, Ontario Canada L3T 5W4
TEL: 1 888 756 8428

Medical Providers only Fax to:
1 866 329 8447 or 1 866 329 6948

I, the undersigned, declare that all the information I have provided in this Claim Form is true and complete. I acknowledge receipt of Travel Healthcare Insurance Solutions/StudentGuard's privacy statement. I authorize any hospital, physician, other medical provider or insurer to provide by any means my complete medical record to **Travel Healthcare Insurance Solutions Inc./STUDENTGUARD** and its insurers for the purpose of administering claims. All information is to be held in complete confidentiality and is not to be released to any party apart from those listed above. Use of my email address will be restricted to insurance inquiries unless I initiate email contact. A photocopy or facsimile transmission of this Claim Form is as valid as the original. I assign my right to payment to the party indicated above.