Assurance Santé
StudentGuard Health Insurance

www.studentguard.com

Travel Healthcare
Insurance Solutions Inc.

PLEASE PRINT CLEARLY

EMERGENCY MEDICAL EXPENSE CLAIM FORM

StudentGuard Policy Number:
Organization or School Name:
Name of Insured/Patient:
Coverage Start Date:
Coverage End Date:
Date of Birth:

Who do we pay: And How: ❑ Cheque (Make cheque payable to): OR ❑ Visa ❑ MasterCard

Name _____ Number _____

Address _____ Expiration Date _____

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.

Signature (Claimant) Date

Assurance Santé
STUDENTGUARD
Health Insurance

PLEASE PRINT CLEARLY

Emergency Medical Expense Claim Form

StudentGuard Policy Number: 3045-21745 L
Coverage Start Date: September 1, 2007
Organization or School Name: The Canadian School of Thought
Coverage End Date: August 31, 2008
Name of Insured/Patient: Maria Garcia Rodriguez Fernandez
Date of Birth: September 10, 1974

Payment By: ☐ **Cheque (Make Cheque payable to):** **OR** ☐ **Visa** ☐ **MasterCard**

Maria Garcia Rodriguez Fernandez — **2454 1000 3003 1798**

123 Intelligence Court, Smart City, SK T4A 1E5 — **April 2008**

Tel: (403) 454-6676 **Fax:** (403) 454-8447 **Email:** mariag123@csit.ca

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:

I was riding my bicycle in Saskatoon on Oct 24 when I was struck from behind by a car. I was taken to the hospital by ambulance as I had injured my face, hands and legs.

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)
24/10/2007	$400	ER Visit – injuries sustained in bicycle accident
24/10/2007	$175	ER Doctor – injuries sustained in bicycle accident
24/10/2007	$200	X-rays – arm, leg and head injuries d/t bicycle accident

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

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Maria Garcia Rodriguez Fernandez — **Oct 25, 2007**
Signature (Claimant) — Date