INTERNATIONAL STUDENT HOSPITAL & MEDICAL INSURANCE CLAIM FORM

Submit Claims to:
SelectCare Worldwide Claims Department
2100 – 250 Yonge Street
Toronto, Ontario, Canada M5B 2L7
Phone: 1-866-261-4441
Fax: 416-340-7152

INSTRUCTIONS

IMPORTANT

- In the event of hospitalization, SelectCare Worldwide® (SCW) must be notified prior to, or within 24 hours of admission to hospital and prior to any surgery or invasive investigations being performed.
- All claims must be reported within 30 days of occurrence.
- Written proof of claim must be submitted within 90 days of occurrence.
- You are responsible for any fees charged for completing this form or issuing supporting documentation.

REQUIREMENTS

- Fully completed and signed Claim Form, sections A, B, C and D.
- Completed Attending Physician/Dentist Statement, Section E.
- Emergency room report and/or hospital records if treated at a hospital or outpatient facility.
- All original bills and/or receipts. Photocopies will not be accepted.
- All bills must be itemized and show dates and costs of all treatment received.

SECTION A: CLAIMANT INFORMATION

Insured's First Name: Last Name:

❑ Male ❑ Female Date of Birth: MM/DD/YYYY Policy #:

Educational Institution: School Enrollment Date: MM/DD/YYYY

Address in Canada

Street Address:

City/Town: Postal Code:

Telephone: ( ) Email:

Country of Origin: Date of Arrival in Canada: MM/DD/YYYY

Name and Address of Family Physician in Country of Origin:

First Name: Last Name:

Street Address:

City/Town: Postal Code: Telephone: ( )

Name and Address of Family Physician in Canada:

First Name: Last Name:

Street Address:

City/Town: Postal Code: Telephone: ( )

Do you have any other insurance coverage? ❑ Yes ❑ No

Do you insurance coverage through your spouse's employer? ❑ Yes ❑ No

If 'Yes', please provide name and address of other insurance company/coverage:

Name:

Street Address:

City/Town: Postal Code: Telephone: ( )

SECTION B: MEDICAL INFORMATION

Brief description of sickness or injury:

Date symptoms or injury first appeared: MM/DD/YYYY Date you first saw physician for this condition: MM/DD/YYYY

In the case of an injury, how, when and where did it happen?

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

If 'Yes', give all dates of treatment and list all medication taken **BEFORE** the effective date of the current policy:

Date: MM/DD/YYYY Medication:

Date: MM/DD/YYYY Medication:

Date: MM/DD/YYYY Medication:

SECTION C: EXPENSES CLAIMED

Name of Provider	Diagnosis	Date of Service (MM/DD/YYYY)	Amount Billed	Amount Paid
1.		MM/DD/YYYY		
2.		MM/DD/YYYY		
3.		MM/DD/YYYY		
4.		MM/DD/YYYY		

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SECTION D: AUTHORIZATION AND CERTIFICATION

SCW is committed to protecting the privacy, confidentiality and security of the personal information we collect, use and disclose. Your personal information will be used only for the purpose of providing you with the requested insurance services. For a copy of SCW 's privacy policy, please contact us.

I authorize any doctor, hospital or facility providing medical or health-related services, and any other insurer, to release and exchange with SCW or its representatives any information that is required to process this claim. I assign to SCW any benefits payable from any other sources for losses covered under this policy, and I authorize and direct such payors to forward payment directly to SCW. I also authorize any third party providing me with assistance in this claims process, to have access to any and all relevant claims information related to the adjudication of my claim with SCW. I confirm I am authorized to act on behalf of my dependants for these purposes. A photocopy of this authorization shall be as valid as the original. I certify that the information provided in connection with this claim is complete, true and accurate.

Full Name of Insured (please print): Date: MM/DD/YYYY

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

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

Signature of policy holder of other insurance in Section A (if applicable):

SECTION E: ATTENDING PHYSICIAN/DENTIST STATEMENT

Name of Patient: Date of Birth: MM/DD/YYYY

Diagnosis Claimed For:

Date of First Consultation: MM/DD/YYYY

1. When did symptoms for this condition, or injury first occur? MM/DD/YYYY
2. Has the claimant/patient ever had the same or similar condition during the 12 months prior to this visit? ❑ Yes ❑ No
   If 'Yes', please advise:
   Date(s) of all medical visits: MM/DD/YYYY MM/DD/YYYY MM/DD/YYYY MM/DD/YYYY
   Diagnosis:
   Treatment Rendered:
3. Was the claimant/patient referred to you? ❑ Yes ❑ No
   If 'Yes', please provide the name/address of referring physician:
4. Are you aware of any other physician in Canada who may have treated this claimant/patient for this or a similar condition? ❑ Yes ❑ No
   If 'Yes', please provide the name/address of this physician:
5. Describe any other diseases or infirmity affecting this claimed condition:
6. List all medication(s) claimant/patient was taking at the time of initial consultation:
7. Was the claimant/patient hospitalized? ❑ Yes ❑ No If 'Yes', name of hospital:
   Date of Admission: MM/DD/YYYY Date of Discharge: MM/DD/YYYY
8. Was any surgery performed? ❑ Yes ❑ No
   If 'Yes', please provide name and address of surgeon and hospital:
9. Was this condition due to pregnancy? ❑ Yes ❑ No
   If 'Yes', date of last menstrual period MM/DD/YYYY and expected date of delivery: MM/DD/YYYY
10. Was this condition due to the use of alcohol, misuse of drugs, or self-inflicted injury? ❑ Yes ❑ No
    If 'Yes', please give details:
11. Was this condition due to a motor vehicle accident? ❑ Yes ❑ No If 'Yes', date of accident/injury: MM/DD/YYYY
12. In your opinion, could treatment for the condition have been postponed until the patient's return to their country of origin? ❑ Yes ❑ No

PHYSICIAN'S CERTIFICATION AND SIGNATURE

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

Physician's Signature:

Physician's Name (please print):

Date: MM/DD/YYYY Email:

Street Address:

City/Town: Postal Code:

Telephone: ( ) Fax: ( )

PHYSICIAN'S STAMP HERE

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