INTERNATIONAL STUDENT MEDICAL EXPENSE CLAIM FORM

Allianz Global Assistance

Please send signed and completed form along with all invoices and proof of payments to Allianz Global assistance:

By Mail:
P.O. Box 277
Waterloo, ON Canada
N2J 4A4

By Email:
studentclaims@allianz-assistance.ca

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PATIENT INFORMATION

Patient Name: _____ Case No, (If known): _____

Group No.: _____ Student ID No.: _____ University Name: _____

Address where you are staying in Canada: _____

City: _____ Province: _____ Postal Code: _____

Phone Number: _____

E-mail: _____

*** **Please note:** By providing your e-mail address and/or phone number, you authorize and consent to Allianz Global Assistance to communicate with you via e-mail or phone.

Patient's Date of Birth: _____ (MM/DD/YYYY) Gender: ☐ M ☐ F ☐ X Patient's Relationship to Policyholder: _____

Home Country _____

POLICYHOLDER INFORMATION (If different from patient)

Policyholder Name: _____ Policyholder's Date of Birth: _____ (MM/DD/YYYY)

EXPENSE INFORMATION

Have you paid for treatment? ☐No ☐ Yes: Total amount being claimed: $_____

If "Yes", please specify service provider name, amount paid and currency of payment. If you have additional expenses please attach an additional page.

Please include proof of payment and itemized receipts for all medical expenses being claimed.

☐Partial or ☐Paid in Full Date of Service: _____ Provider name: _____ Amount Pd: _____

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***** Please note: All claim payments will be in Canadian Dollars. Claim payments that would violate any applicable national economic or trade sanctions law or regulations are prohibited.**

MEDICAL INFORMATION

Please describe briefly, the situation leading you to seek medical attention, including the diagnosis.

_____

_____

Were medical service required as a result of a work related accident or motor vehicle accident? ☐ Yes ☐ No
If "Yes", please provide details and include an accident report with this form.

_____

_____

Name of Hospital: _____ Date of Occurrence: _____ (MM/DD/YYYY)

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AUTHORIZATION

CERTIFICATION AND AUTHORIZATION FOR RELEASE OF INFORMATION

By signing below, you authorize the provider, on your behalf, to submit claims and obtain payments for all services performed for you, your spouse and your dependents during the Coverage Period.

You agree to take all reasonable steps to ensure all information submitted to Allianz Global Assistance Canada (hereafter referred to as "AGAC") by the Provider is complete and accurate and will notify AGAC if you become aware of any discrepancies with the services billed on your behalf.

You understand that the information provided by you to AGAC about yourself, your spouse and your dependents will be used by AGAC for claim adjudication and any other services necessary in the administration of these benefits which may include the exchange of information with other parties to administer this claim.

You confirm that you are authorized by your spouse and/or dependents to disclose and receive information about them that is used for the aforementioned purposes. You confirm that your spouse and/or dependents understand that this information may be seen by you, the member.

The cost (if any) of obtaining information required for the payment of the claim is at the expense of the patient or plan member. All claims must be submitted within 12 months from the date of service unless otherwise stated in your benefit plan documentation.

You confirm that you, your spouse and/or dependents authorize AGAC access to your medical records[1] for the purpose of auditing the claimed expenses and or any other services relating to the adjudication of your claims.

Allianz shall have full rights of subrogation, including the right to proceed in the *Insured Person's* name against third parties who may be responsible for a claim arising or for providing indemnity or benefits similar to the benefits under this *Certificate. The Insured Person* shall give Allianz all such assistance as is reasonably required to secure Allianz's rights and remedies, including the execution of all documents necessary to enable Allianz to bring suit in the name of the *Insured Person,* as applicable.

Subrogation from a Third Party: In the event of a payment under this insurance, Allianz Global Assistance has the right to proceed in the name of any insured person against third parties who may be responsible for giving rise to a claim.

I agree that a photocopy or facsimile of this authorization shall be valid as the original and that this authorization shall be considered valid for the duration of this claim, but not to exceed two years from the date it is signed. I understand information about me may be reviewed in the event that this plan is audited.

CERTIFICATION: The undersigned hereby certifies that the information provided by him or her on this form is complete and accurate to the best of each of his or her knowledge and belief. In the event of a false or misleading statements and/ or claims, coverage can be void. The undersigned certifies he or she have the authority to provide all required authorization and information.

Name of Patient (Please print): _____ Date: _____
(MM/DD/YYYY)

Home Address: _____

Signature of **Patient / Designated Legal Proxy** *: _____ Phone No: _____

Signature of **Policy Holder**: _____ Date: _____

CASL AUTHORIZATION

I have read, understand and consent to receive communications from Allianz Global Assistance by email. If you wish to no longer receive communications by email from Allianz Global Assistance, please contact unsubscribe@allianz-assistance.ca and include you full first name, last name, policy/certicate number and/or case number and your email address. Please refer to our Privacy Policy or Contact US for more details.

Signature of **Patient / Designated Legal Proxy *:** _____ **Date:** _____
(MM/DD/YYYY)

* If the patient is a minor, his/her legal guardian must sign on his/her behalf. If a legal representative other than the patient's legal guardian signs this form, (power of attorney, executor/executrix etc.) we require proof of "Legal Representative" status.

[1] IMPORTANT: Medical records exclude 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.

If sending original documents, be sure to keep a copy for your records.
If you have questions, please call us at 1-800-363-1835 (within North America), 011-1-519-742-2800 (from outside North America) or e-mail us at caclaimsInquiry@allianz-assistance.ca.

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