International Student Medical Claim Form

INGLE LEWER INTERNATIONAL INSURANCE

PLEASE PRINT CLEARLY

SECTION A: Claimant / Insured

FIRST NAME	SURNAME	EMAIL ADDRESS	DATE OF BIRTH (DD/MM/YYYY)

■ Male ■ Female ■ Non-Binary

POLICY NUMBER	PHONE NUMBER

ORGANIZATION OR SCHOOL NAME

Mailing Address in Canada

UNIT	STREET NAME AND NUMBER	CITY	PROVINCE	POSTAL CODE

SECTION B: Authorization to Pay

This claim is payable to: ■ Insured ■ Parent / Guardian ■ Hospital / Clinic ■ Physician ■ Other

Relationship to Insured:

Payment Method: **Canadian Bank Accounts Only**: ■ Cheque ■ Electronic Funds Transfer ■ Interac e- transfer ■ I do not have a Canadian bank account

BANK NAME	ACCOUNT HOLDER NAME	PAYEE NAME (IF DIFFERENT FROM ACCOUNT HOLDER)

ACCOUNT HOLDER ADDRESS

PAYEE EMAIL	TRANSIT NUMBER (5 DIGITS ONLY)	FINANCIAL INSTITUTION (3 DIGITS ONLY)	ACCOUNT NUMBER (7 DIGITS ONLY)

INSURED NAME (PLEASE PRINT) | SIGNATURE OF MEMBER/ GUARDIAN (YOU MUST SIGN HERE) | DATE SIGNED (DD/MM/YY)

SECTION C: Other Insurance Coverage

Does the insured person currently have provincial or government coverage of any kind? ■ Yes ■ No

IF YES, provide the name of the provincial or government agency providing coverage

Is the insured person covered by another medical or travel insurance policy (including coverage through a spouse, parent, or guardian?) ■ Yes ■ No

IF YES, provide details of other insurance coverage:

FULL NAME OF POLICYHOLDER	INSURANCE COMPANY

POLICY/ PLAN NUMBER	ID/ CERTIFICATE NUMBER	EMPLOYER GROUP NUMBER (IF APPLICABLE)	EMPLOYER NAME (IF APPLICABLE)	EMPLOYER PHONE (IF APPLICABLE)

SECTION D: Expenses Claimed

NAME OF MEDICAL PROVIDER	REASON FOR VISITING THE DOCTOR & DIAGNOSIS	DATE OF SERVICE	AMOUNT BILLED ($)	AMOUNT PAID ($)

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CONTINUED

Date of Symptoms First appeared (DD/MM/YY):

Description of insured's sickness or injury (if this space is insufficient, additional information can be attached):

ATTACH ALL INVOICES AND RECEIPTS AND SUBMIT YOUR CLAIM BY EMAIL TO:

claims@inglelewer.ca

OR SUBMIT YOUR CLAIM BY MAIL TO:

IngleLewer/AF24
260 Hearst Way
Suite 310, Ottawa, Ontario,
CANADA K2L 3H1

+1-888-575-1231
toll-free from Canada and the USA

Local Collect numbers:
+1 514-375-8234

I authorize any doctor, medical practitioner, hospital, facility providing medical or health-related services, third-party administrator, provincial plan, and any other insurer to release and exchange with **HDI Global Specialty SE, Ingle Lewer, Lewer Canada Ltd, and AF24/ Penfield Medical Cost Containment Inc.** or any of their representatives, any information (including personal health data and records) required to process this claim. I authorize any third party providing me with assistance in this claim process to have access to any and all relevant claims information related to the adjudication of my claim with **HDI Global Specialty SE, Ingle Lewer, Lewer Canada Ltd, and AF24/ Penfield Medical Cost Containment Inc.** I authorize **Ingle Lewer, Lewer Canada Ltd, and AF24/ Penfield Medical Cost Containment Inc.** to coordinate the payment of benefits with any insurance carriers that may have a liability for this claim and assign to **HDI Global Specialty SE, Ingle Lewer, Lewer Canada Ltd, and AF24/ Penfield Medical Cost Containment Inc.** any benefits payable from any other sources for losses covered under this policy, and authorize and direct such payers to forward payment directly to **HDI Global Specialty SE, Ingle Lewer, Lewer Canada Ltd, and/or AF24/ Penfield Medical Cost Containment Inc.** I confirm below by my signature that I am authorized to act on behalf of any of my dependants for these purposes. A photocopy of this authorization shall be as valid as the original. I authorize **Ingle Lewer, Lewer Canada Ltd, and AF24/ Penfield Medical Cost Containment Inc.** to coordinate the payment of benefits with any insurance carriers that may have a liability for this claim and assign to **HDI Global Specialty SE, Ingle Lewer, Lewer Canada Ltd, and AF24/ Penfield Medical Cost Containment Inc.** any benefits payable from any other sources for losses covered under this policy, and authorize and direct such payers to forward payment directly to **HDI Global Specialty SE, Ingle Lewer, Lewer Canada Ltd, and/or AF24/ Penfield Medical Cost Containment Inc.** I certify that the information provided in connection with this claim is complete, true, and accurate.

☐ **Invoices and receipts attached**

NAME OF INSURED (PLEASE PRINT)	SIGNATURE OF INSURED (IF UNDER AGE 16, SIGNATURE OF A PARENT OR LEGAL GUARDIAN)	DATE SIGNED (DD/MM/YY)