In-Canada Claim Form

MSH AMERICAS studyinsured™

PLEASE PRINT

SECTION A: CLAIMANT / INSURED

INSURED PERSON

Full Name	Email address	Date of Birth (DD/MM/YYYY)
☐ Male ☐ Female ☐ Non-binary	Policy Number	

MAILING ADDRESS IN CANADA

Unit #	Street Name and #	City	Province	Postal Code

SECTION B: AUTHORIZATION TO PAY

THIS CLAIM IS PAYABLE TO:

☐ Insured ☐ Parent/Guardian (Full Name): ☐ Hospital/Clinic ☐ Physician

☐ Other: If applicable, I authorize payment of this claim to (please print):

PAYMENT METHOD - CANADIAN BANK ACCOUNTS ONLY

☐ Cheque ☐ Electronic Funds Transfer (For EFT payments, complete fields below and check for accuracy). **Example here**

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 Insured Person/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 (DD/MM/YY)	Amount Billed ($)	Amount Paid ($)

Date 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:
studentclaims@studyinsured.com

OR SUBMIT YOUR CLAIM BY MAIL TO:
StudyInsured Assistance™
150 King St West, Suite 602
PO Box 75,
Toronto ON M5H 1J9

+1 866.883.9485
toll-free from Canada and the USA

+1 416.640.7862
collect where available

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 Lloyd's, StudyInsured, or its 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 Lloyd's and StudyInsured. I authorize StudyInsured to coordinate the payment of benefits with any insurance carriers that may have a liability for this claim and assign to Lloyd's and StudyInsured any benefits payable from any other sources for losses covered under this policy, and authorize and direct such payers to forward payment directly to Lloyd's and StudyInsured. 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 StudyInsured™ / MSH International (Canada) Ltd. to coordinate the payment of benefits with any insurance carriers that may have a liability for this claim and assign to Lloyd's and StudyInsured™ and MSH International (Canada) Ltd. any benefits payable from any other sources for losses covered under this policy, and authorize and direct such payers to forward payment directly to Lloyd's and StudyInsured™ and MSH International (Canada) Ltd.

I certify that the information provided in connection with this claim is complete, true, and accurate.

Name of Insured (please print)

Signature of Insured (if under age 16, signature of parent or legal guardian) | Date signed (DD/MM/YY)