GlobalExcel®

73 Queen Street
Sherbrooke, Qc J1M 0C9
1-800-336-9224 or 819-566-8698

INTERNATIONAL STUDENTS
CLAIM FORM

Certificate/Policy No.: _____

Claim No.: _____

IMPORTANT: You must complete all sections of the form so the evaluation of the claim can proceed without delay. It may be returned to you if the information is incomplete or incorrect.

SECTION A — TO BE COMPLETED BY INSURED

Last Name: First Name:

Date of Birth (M/D/Y): Phone Number: E-mail:

Address - # and Street: Apt.:

City: Province: Postal Code:

Do you have health benefits or services provided under any other health plan (including Government Health Insurance Plan)? ☐ Yes ☐ No

Name of the insurance company: Policy or Certificate #:

Is this reimbursement request the result of an accident? ☐ Yes ☐ No If Yes, please provide details (date, type, circumstances):

SECTION B — INFORMATION ON EXPENSES INCURRED

In the case of a PREGNANCY, indicate the date of last menstrual cycle (M/D/Y): _____

Date (M/D/Y)	**Diagnosis** (why you consulted) and **Description of Services** (e.g. Doctor's visit, physiotherapy, prescription drug, etc.	**Charges / Fees**
		$
		$
		$
		$

This claim is payable to: ☐ Insured to the above address ☐ Physician ☐ Clinic/Hospital ☐ Parent/Guardian ☐ Other

If payable to the physician, clinic/hospital, parent/guardian or another person, please indicate: Name:

Address - # and Street: Apt:

City: Province: Postal Code:

Phone Number: Fax: E-mail:

Physician's signature:

(Only required if physician submits for direct reimbursement from Global Excel. See instructions on the back[1])

Patient's signature:

(Required to authorize reimbursement to an individual other than the insured.)

SECTION C — AUTHORIZATION AND RELEASE - TO BE SIGNED BY INSURED

1. I understand that Global Excel Management Inc. may investigate my claim. By signing this claim form, I also hereby direct and authorize any physician, healthcare practitioner, hospital or other medical care facility, pharmacy, the Ministry of Health or any other person who has attended and examined me or who has knowledge or records of me or my health, to furnish to Global Excel Management Inc. any or all information with respect to my sickness, injury, medical history, consultations, medicines or treatment and copies of all hospital or medical records for the purpose of investigating my claim.
2. I assign to Global Excel Management Inc. any indemnity obtainable from other sources for covered losses under this policy. I also direct these sources to forward payment to Global Excel Management Inc. for my claims submitted by Global Excel Management Inc. with regard to these losses and to exchange information that facilitates this process.
3. I understand that my insurance shall be void if, whether before or after the loss, any person has concealed or misrepresented any fact or circumstance concerning this claim.

Insured's signature: Date (M/D/Y):

Global Excel Use Only	Cheque #:	Date (M/D/Y):	Claim #:

IMPORTANT INFORMATION ON THE BACK — PLEASE COMPLETE THE OTHER SIDE OF THIS FORM

SECTION D — TO BE COMPLETED IF COSTS WERE INCURRED DURING A TEMPORARY TRIP.

☐ Outside your province or territory of residence ☐ Outside Canada
(Please consult your policy, in the Insurance Agreement Section to know if you should complete this section for the costs incurred.)

Reason for trip: ☐ Vacations ☐ Training program* ☐ Country of permanent residence ☐ Other, please specify: _____

* If the stay is for a training program, please provide a letter stating that the training is recognized by your institution of learning.

Date of departure (M/D/Y): _____ Date of return (M/D/Y): _____

Please include a proof of travel dates (e.g. copy of passport, airline tickets, gas receipt).

Medical services received - Please indicate the reason you received medical treatment (diagnosis, nature of sickness or injury): _____

Describe the medical treatment received (e.g. consultations, diagnostic services, surgery, etc.). If space is insufficient, please attach another sheet of paper.

In what city and country were the services received: _____

If this claim is related to an accident, please provide details (date, type, circumstances): _____

Claimed Amount: $ _____ ☐ Canadian ☐ Other, please specifiy: _____ You will be reimbursed in Canadian currency, at the exchange rate on the date you are reimbursed.	Have the bills been paid? ☐ Yes ☐ No ☐ In full ☐ In part: $ _____

IMPORTANT INFORMATION

- Send only originals of all bills or receipts (copies are not acceptable). Originals will not be returned to you. As such, please conserve copies for your files.
- All claim forms must be signed by the insured person.

PRESCRIPTION DRUGS

- When you submit a claim form for prescription drugs, please attach the original receipts to the claim form.
- Receipts for medications must clearly indicate the name of the prescribing doctor, the identification number of the medication (DIN), the name of the medication, the date, the quantity and the total cost.

HEALTH PROFESSIONALS (physiotherapist, chiropractor, etc.)
Please attach a detailed note or a receipt which indicates the following information:

- Name of the patient
- Name of the health professional
- License or registration number of the health professional
- Health professional category
- Diagnosis
- Date(s) of the visit(s)
- Cost per treatment

MEDICAL APPLIANCES

If the terms and conditions of your policy require it (consult your policy to confirm), please provide the written recommendation of your treating physician for all prescribed appliances or equipment, including the diagnosis.

Please indicate the length of time that this equipment or medical appliance must be utilized, from:

(M/D/Y)_____ to: (M/D/Y)_____

Send you claim form and your original bills or receipts to:

Global Excel Management Inc.
73 Queen Street, Sherbrooke, Québec J1M 0C9

For claim inquiries, call:

1-800-336-9224 or **819-566-8698**

[1] DIRECT BILLING - NOTE TO THE PROVIDER OF MEDICAL SERVICES

To bill Global Excel directly, you can fax this claim form, under the condition that it is completed and signed by the insured and the physician.

FAX: 1-877-955-8466

FOR COMPANY USE ONLY

Fraud Verification A: **Fraud Verification B:**