Ingle INTERNATIONAL™

You are not alone

INTERNATIONAL STUDENT INSURANCE CLAIM

RETURN COMPLETED FORMS TO:

INGLE INTERNATIONAL
IMAGINE FINANCIAL LTD.
460 RICHMOND ST. W., SUITE 100
TORONTO, ON M5V 1Y1
P 416.730.8488 | 1.888.386.8888
F 416.730.1878
E helpline@ingleinternational.com

How to fill out this form

- Make sure that all of your personal information is entered, including how to contact you
- Make sure all medical questions are answered
- Make sure we know who to make payment to
- **Make sure to sign the authorizations on the back of this form**

Claims cannot be paid without a fully completed, signed claim form.

Claims Management & Assistance By:
Global Excel Management Inc.

Name of Insured: Given Name _____ Family Name _____ Sex ☐M ☐F

Policy Number: _____ Passport Number: _____ Home Country: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Home Phone: (____) _____ Other Phone: (____) _____ Email: _____

Date of Birth: YY / MM / DD Arrival Date in Canada: YY / MM / DD Planned Departure Date: YY / MM / DD

Are you covered under any other health insurance? Company: _____ Policy No.: _____

Information on your regular physician in your home country – Name: _____

Phone Number: _____ Fax Number: _____

Address: _____

_____

CLAIM DETAILS

Please fill in the following details in plain English (no diagnostic codes, DIN numbers, etc.):

Name of Provider	Description of Service & Diagnosis	Date of Service	Fees Billed ($ CAD)	Paid ($ CAD)
		YY / MM / DD		
		YY / MM / DD		
		YY / MM / DD		
		YY / MM / DD		
		YY / MM / DD		
		YY / MM / DD		

This claim is payable to:

☐ the insured person ☐ a parent/guardian (indicate name) ☐ the facility ☐ the attending physician ☐ other

Indicate name if parent/guardian or other: _____ **Attach all original invoices and/or receipts.**

Attending Physician: _____ Institution: _____

Phone: (____) _____ Fax: (____) _____ Email: _____

Address: _____

PLEASE PROCEED TO PAGE 2 ON REVERSE.

INTERNATIONAL STUDENT INSURANCE CLAIM

Ⓐ Is this claim related to an accident? ☐ Yes (provide details) ☐ No

Ⓑ Is this claim related to a car accident? ☐ Yes (complete section C) ☐ No (complete section D)

Ⓒ Complete **ONLY** if your loss was the result of an automobile accident. Please fill in the information below for both vehicles.

Information about the vehicle owner and vehicle in which **YOU** were an occupant	Name of vehicle owner:		Phone number of owner ( )
	Address of vehicle owner:		Apt. #
	Auto Insurance Company:	Phone ( )	Auto Insurance Policy No.:
Information about **OTHER** vehicle(s) involved	Name of **OTHER** vehicle owner:		Phone of **OTHER** owner ( )
	Address of **OTHER** vehicle owner:		Apt. #
	Auto Insurance Company:	Phone ( )	Auto Insurance Policy No.:

Is a police report attached? ☐ Yes ☐ No	Accident Location:	Accident Date	M	D	YEAR

Has a claim been reported to the automobile insurance provider? ☐ Yes ☐ No If Yes, please provide that claim number:

Ⓓ Were you hospitalized overnight? If so, please provide the date and the name of the hospital:

Authorisations and Releases

I, the insured under this policy or his/her legal guardian, hereby authorise the sharing and disclosure of information related to my claim or my medical history among or between any of the following persons or entities:

- the attending physician at the time of my claim,
- any institution where I was treated,
- my physician in my home country,
- the school or school board I am attending,
- Ingle International and Imagine Financial Ltd.,
- the insurer administering or underwriting this policy (see your policy booklet for identification of the insurer), and
- the claims management group or assistance company appointed by the insurer (see the front page of this form, or your policy booklet, for information on the claims management group or assistance company).

I authorise this for the purpose of providing information required by the insurer or its claims management group to process my claim, and also for the purpose of Ingle International and Imagine Financial Ltd. to inquire on the status of my claim for my benefit. This authorisation takes effect immediately and lasts indefinitely unless revoked by me in writing. I understand that if my medical records are not released to the insurer, benefits may not be payable.

I assign to the insurer any benefits related to this claim which would be payable to me from any other source, and authorise the insurer to collect any such benefits on my behalf.

I certify that the information I have provided in this claim form is accurate and complete.

Print Name _____ Relationship to insured, if not signed by insured _____

Signature _____ Date _____

Witness' Signature _____ Witness' Name _____ Date _____

IMPORTANT – DID YOU:

- ☐ Answer every appropriate question on both the front and back of this form?
- ☐ Provide current contact information so that we can correspond with you?
- ☐ Indicate to whom benefits are payable?
- ☐ Sign the authorisations and releases above?
- ☐ Attach all original invoices and receipts?

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