Student Accident Insurance Claim Form

Student Accident Insurance BY STUDYINSURED™

INSTRUCTIONS

NOTE: IF THE INSURED IS A MINOR, THIS FORM SHOULD BE COMPLETED AND SIGNED BY A PARENT/GUARDIAN.

IMPORTANT

- Ensure payment information in Section I is complete and accurate.
- All claims must be reported within 60 days of occurrence.
- Written proof of claim must be submitted within 90 days of occurrence.
- You are responsible for all fees charged for any supporting documentation.
- Failure to complete and sign this form in its entirety or submit supporting documentation will delay claim processing.

CLAIMS SUBMISSION

- **Please complete ONLY those sections which are relevant to your claim which you are submitting, and ensure this form is signed before submitting with all invoices, physician and medical reports detailing treatment and treatment dates, and prescription pharmacy receipts. Keep copies for your records.**
- Claimants must attach a copy of the emergency room report and all hospital records if treatment was received at a hospital.
- If you have paid for services, you must submit all original itemized invoices and payment receipts from the medical service provider or hospital detailing treatment and treatment dates. Photocopies of receipts will not be accepted.

SECTION A: INSURED PERSON / CLAIMANT

INSURED PERSON

Last Name	First Name	Date of Birth (DD/MM/YY)
☐ Male ☐ Female ☐ Non-binary	School Board / School	Policy Number

Unit #	Street Name and #	City	Province	Postal Code

Telephone	Mobile	Email

CLAIMANT (IF DIFFERENT FROM INSURED PERSON)

First Name	Last Name	Relationship to Insured

Unit #	Street Name and #	City	Province	Postal Code

Telephone	Mobile	Email

INSURED PERSON'S FAMILY PHYSICIAN

Full Name	Clinic Name or Practice

Unit #	Street Name and #	City	Province	Postal Code

Telephone	Fax

SECTION B: OTHER INSURANCE COVERAGE

Is there coverage for this type of claim under any other insurance or benefit plan (e.g. Group insurance through an employer, or insurance through a credit card)? ☐ 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)

Credit Card Number (if applicable)	Type of Credit Card (if applicable)	Policyholder Phone Number

SECTION C: ACCIDENT CLAIM

Describe fully how the accident occurred:

(If this space is insufficient, additional information can be attached)

Did accident occur at school or during a school activity? ☐ Yes ☐ No

Date of Accident (DD/MM/YY)	Time of Accident (hour)

Location of Accident

Nature of Injury

Full Name of Witness 1	Phone Number of Witness 1
Full Name of Witness 2	**Phone Number of Witness 2**

Has the insured person ever been treated for this, or a similar or related, condition before? ☐ Yes ☐ No

Date insured first saw a physician for this, or a similar or related, condition (DD/MM/YY):

Please provide all dates of treatment and list all medications taken for this, or a similar or related, condition before the effective date of the policy:

Treatment Date (DD/MM/YY)	Medication

SECTION D: CRITICAL ILLNESS CLAIM

SUBSECTION D-1: CRITICAL ILLNESS CLAIM INFORMATION

Date the insured person's condition was diagnosed and/or surgery performed (DD/ MM/YY):

Name of physician who made the diagnosis:

Date of first consultation with a medical practitioner regarding this condition (DD/MM/YY):

SUBSECTION D-2: HISTORY OF MEDICAL VISITS

Name of Doctor/Hospital	Address	Telephone

Please provide any further information that you think might be relevant to this claim:

SECTION E: TRAVEL MEDICAL INSURANCE

SUBSECTION E-1: INSURED PERSON'S TRAVEL INFORMATION

INSURED PERSON'S ADDRESS WHILE AWAY FROM RESIDENCE

Address			Unit Number
City	**Province/State**	**ZIP/Postal Code**	**Country**
Phone Number (include country code)	**Email Address**		
Departure Date From Place of Residence (DD/MM/YY)	**Scheduled Return Date to Place of Residence (DD/MM/YY)**		

SUBSECTION E-2: TRAVEL MEDICAL CLAIM INFORMATION

TREATING PHYSICIAN FOR THIS CLAIM

Full Name	Clinic Name or Practice			
Street Address	Unit #	City	State/Province	Postal Code
Phone Number (include country code)	Fax			

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

Date symptoms first appeared or the injury occurred (DD/MM/YY):

Has the insured person ever been treated for this, or a similar or related, condition before? ☐ Yes ☐ No

IF YES, Date the insured person first saw a physician for this, or a similar or related, condition (DD/MM/YY):

Provide all dates of treatment and list all medications taken for this, or a similar or related, condition before the effective date of the current policy:

Treatment Date (DD/MM/YY)	Medication

SECTION F: TRIP CANCELLATION

The following documents are required:

a) A medical certificate completed by the attending physician stating why travel was not possible as booked, if the claim is for medical reasons; or
b) A report from the police or other responsible authority documenting the reason for the delay if the claim is due to a misconnection.

As applicable:

a) complete original unused transportation tickets and vouchers;
b) original passenger receipts for the new tickets you had to purchase;
c) original receipts for the travel arrangements you had paid in advance and for the extra hotel, meal, telephone and taxi expenses you may have had;
d) the entire medical file of any person whose health or medical condition is the reason for your claim;
e) any other invoice or receipt supporting your claim.

SUBSECTION F-1: TRIP CANCELLATION INFORMATION

Scheduled departure date (DD/MM/YY): Scheduled return date (DD/MM/YY):

Describe the circumstances which resulted in the cancellation of the trip:

Date of the cause of cancellation (DD/MM/YY): Date travel agent/airline notified (DD/MM/YY):

SUBSECTION F-2: MEDICAL INFORMATION

Description of sickness or injury (if this space proves insufficient, additional information can be attached).

Diagnosis

Has the insured person ever been treated for this, or a similar or related, condition before? ☐ Yes ☐ No

Date the insured person's symptoms first appeared or injury occurred (DD/MM/YY):

Date insured first saw a physician for this, or a similar or related, condition (DD/MM/YY):

DETAILS OF TREATING PHYSICIAN (IF APPLICABLE)

Full Name	Clinic Name or Practice

Unit #	Street Address

City	State/Province	Country	ZIP/Postal Code

Phone	Fax

SECTION G: EXPENSES CLAIMED

Type of Claim (Indicate section e.g. Section C Accident Claim)	Name of Service Provider	Reason for Visit & Nature of Service	Date of Service (DD/MM/YY)	Amount Billed ($)	Amount Paid ($)

SECTION H: AUTHORIZATION AND CERTIFICATION

Certain Lloyd's Underwriters ("Lloyd's"), StudyInsured™ ("StudyInsured"), its agents, and administrators, are obliged to collect and retain certain personal and/or health information about you in connection with your insurance coverage. We use and disclose this information only for the purposes of administering your policy/policies of insurance, providing customer service, and in assessing and paying claims. We are committed to protecting the privacy, confidentiality, and security of the personal information we collect, use, retain, and disclose. Your personal information will be used only for the purposes of providing you with the requested insurance services. Lloyd's and StudyInsured's complete privacy policies are available upon request.

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 understand my claim may be subject to review and investigation and I give Lloyd's, StudyInsured, or their authorized agents authority to acquire any documents or statements from other insurers, financial institutions, travel suppliers, any company or public/private organization which can provide information related to my claim, and I hereby consent to the disclosure of such information to other sources as may be required for the processing of my claim.

I hereby assign any benefits obtainable from other sources for losses covered under this policy. I also direct these sources to forward payment for my claim submitted with regard to these losses. A photocopy or faxed copy of this authorization is acceptable.

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

Full Name of Insured (please print)	If Insured is under age 16, Full Name of Parent/Guardian (please print)
Signature of Insured (if Insured is under age 16, Signature of Parent/Legal Guardian)	Signature of Policyholder of Other Insurance in Section B (if applicable)
Date (DD/MM/YY)	Date (DD/MM/YY)

SECTION I: AUTHORIZATION TO PAY

THIS CLAIM IS PAYABLE TO:

☐ Insured at the address in Section A above ☐ Parent/Guardian ☐ Hospital/Clinic ☐ Physician/Dentist

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

PAYMENT METHOD

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

Account Holder Name	Financial Institution Number	Transit Number	Account Number

CLAIMS SUBMISSION:

StudyInsured™
150 King St West, Suite 602 - PO Box 75,
Toronto ON M5H 1J9

accidentclaims@studyinsuredstudentaccident.com
fax: +1-416-730-1878

1-866-883-9485
toll-free in North America

+1-416-640-7862
collect where available