



PLEASE PRINT CLEARLY

Emergency Medical Expense Claim Form

StudentGuard Policy Number: Organization or School Name: Name of Insured/Patient:	Coverage Start Date: Coverage End Date: Date of Birth:
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Payment By: <input type="checkbox"/> Cheque (Make cheque payable to): _____ Name _____ Address _____	<input type="checkbox"/> Visa <input type="checkbox"/> Mastercard _____ Number _____ Expiry Date _____
Tel: (_____) _____ Fax: (_____) _____	Email: _____

1. Do you have any other insurance? You must answer NO or YES (Include ANY other insurance.) *If YES, provide details:*

2. Were you hurt in an accident? NO or YES Tell us what happened, including when and where the accident happened:

3. Tell us WHEN and WHY you saw the doctor (below). Original bills and receipts must be sent with this Claim Form for us to pay you.

Date (d/m/y)	Cost/Currency	Why you needed medical care (Diagnosis)

FOR DIRECT BILLING BY MEDICAL PROVIDERS ONLY: Complete the above section and answer the questions below.

For prompt reimbursement as detailed below, FAX this signed form to StudentGuard.

Rx given X-ray Ordered Lab work Ordered Other/Details _____

A) Is this **emergency** treatment, medically necessary to identify and/or treat an **acute, unexpected** sickness? NO or YES

OR B) Is this treatment pre-arranged and/or given to maintain the stability of a chronic sickness or condition? NO or YES

AND C) Did the same or similar conditions occur in the 90 days prior to the Coverage Start Date? NO or YES

If YES, provide details and dates: _____

If you answer YES to A) we will reimburse you directly.

If you answer YES to B) or C), have the insured pay for this visit. Questions? Please call the number below.

 Doctor's Name **PRINT**

 Date

 Dr.'s Signature (only required if Dr. submits for direct payment)

ATTACH ALL BILLS and MAIL TO:

StudentGuard Claims
 300 John Street, Suite 610
 Thornhill, Ontario Canada L3T 5W4
TEL: 1-888-756-8428

Medical Providers only Fax to:
1-866-329-8447 or 1-866-329-6948

I, the undersigned, declare that all the information I have provided in this Claim Form is true and complete. I acknowledge receipt of Travel Healthcare Insurance Solutions/StudentGuard's privacy statement. I authorize any hospital, physician, other medical provider or insurer to provide by any means my complete medical record to ACE INA Life Insurance or Travel Healthcare Insurance Solutions Inc. /StudentGuard for the purpose of administering claims. All information is to be held in complete confidentiality and is not to be released to any party apart from those listed above. Use of my email address will be restricted to insurance inquiries unless I initiate email contact. A photocopy or facsimile transmission of this Claim Form is as valid as the original. I assign my right to payment to the party indicated above.