

HEALTH INSURANCE CLAIM FORM

for
International Students in Manitoba Universities, Colleges and Schools
GROUP POLICY NO. 42074

NOTE: A separate claim form is provided for Prescription Drug Claims

PART 1 - TO BE COMPLETED BY THE INSURED STUDENT

1. _____ Identification Number
 Last Name Given Name
 Student's Birthday Day Month Year
 Address Apt.0
 City Province Postal Code Institution Division
 Telephone : _____
2. Is this claim for treatment of a dependent? Yes No
 If yes, Name of Dependent _____ Birthdate of dependent _____ Relationship to Student _____
3. If claim was due to accident, please provide location of accident _____
 Date of accident _____ How occurred _____
4. Are you entitled to other insurance expenses? Yes No If yes, name and address of other insurer (e.g. Student Accident Plan, Government Plans, Autopac) (if motor vehicle involved, provide Autopac claim number) _____
5. If yes to question #4 and patient is a dependent child, please provide employee's birthdate _____ and spouse's birthdate _____

PART 2 - MEDICAL AUTHORITY OF PATIENT OR GUARDIAN

I hereby authorize any hospital, physician, or other person who has attended me or the claimant to furnish to THE GREAT-WEST LIFE ASSURANCE COMPANY or its representative, any and all information with respect to this illness or injury, medical history, consultations prescriptions or treatment, and copies of all hospital or medical records related to the claim. A photostatic copy of this authorization shall be considered as effective and valid as the original.
 I also certify that the information given is true, correct and complete to the best of my knowledge.

Date _____ Year _____ **STUDENT SIGNATURE** _____
 (The student signature is required in order to process Benefits)

BENEFITS WILL BE ASSIGNED TO PROVIDER OF SERVICE UNLESS RECEIPTS ARE SUBMITTED WITH CLAIM INDICATING PAYMENT HAS BEEN MADE. THE PATIENT IS FINANCIALLY RESPONSIBLE FOR CHARGES NOT COVERED BY THIS POLICY.

PART 3 - ATTENDING PHYSICIAN'S/PROVIDER'S STATEMENT

1. Is this service being performed at the request of a third party? Yes No
2. Is the patient's condition the result of an accident? Yes No
3. To the best of your knowledge, when did the accident happen? DAY _____ MONTH _____ YEAR _____
4. WAS AN OPERATION PERFORMED? Yes No NATURE OF OPERATION _____
 DATE PERFORMED _____ BY DOCTOR _____
5. WAS CLAIMANT IN HOSPITAL? Yes No FROM: _____ TO: _____

PLEASE PRINT

Physician's/Provider's Name _____
 Physician's/Provider's Address _____
 Physician's/Provider's Postal Code _____ Physician's/Provider's Telephone Number _____
 Physician's/Provider's Signature _____

Note to Physicians/Providers and Claimants: Payments for claims will be made in accordance with the fee levels as stated in the M.H.S.C. Physician's Manual.

Note to Physicians/Providers: Please see reverse side for completion of diagnosis and tariffs. THE PHYSICIAN'S/PROVIDER'S SIGNATURE IS REQUIRED IN ORDER TO PROCESS BENEFITS.

Completed Claim Form is to be Forwarded to:
GREAT-WEST LIFE HEALTH & DENTAL BENEFITS
 P.O. BOX 3050
 WINNIPEG MB R3C 0E6
 1-800-957-9777 (204) 942-3589

