



**AIG Commercial Insurance
Company Of Canada**
145 Wellington Street West
Toronto, ON M5J 1H8
416-596-4005 | 1-877-317-8060
ahclaimscan@aig.com | www.aig.com

**PROVINCIAL / MEDICAL INSURANCE CLAIM FORM
POLICY NO. : 9028300**

PLEASE PRINT

NAME OF SCHOOL: _____

STUDENT'S NAME _____ SEX M () F ()

M	D	Y
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(LAST NAME) (FIRST NAME) DATE OF BIRTH

FULL ADDRESS IN CANADA _____

STREET PHONE NO.

CITY PROVINCE POSTAL CODE

(A) THIS SECTION TO BE COMPLETED IF CLAIMING FOR PRESCRIPTION DRUGS, PARAMEDICAL SERVICES, X-RAYS OR LABORATORY FEES.

Name of Patient	Date Service Rendered M/D/Y	Nature of Illness or injury	Claim Description	Amount Charged	Name of Doctor Prescribing Service

PERSONAL INFORMATION NOTICE: I understand that the information provided by me on this claim form and otherwise in respect of my claim, is required by AIG Commercial Insurance Company of Canada, its reinsurers and authorized administrators (the "Insurer") to assess my entitlement to benefits, including but not limited to determining if coverage is in effect, investigating the applicability of exclusions and co-ordinating coverage with other insurers. For these purposes, the Insurer will also consult its existing insurance files about me, collect additional information about and from me, and where required, collect information from and exchange information with, third parties.

CERTIFICATION: The statements I provide in completing this claim form and otherwise in respect of my claims are true and complete to the best of my knowledge and belief. In the event of a false or misleading statement in the making of this claim, coverage can be cancelled, payment of benefits denied and past claims payments recovered. I agree to refund to the Insurer, the amount of any payments made in the event that such amounts should not have been paid in respect of my claim.

AUTHORIZATION: I authorize, for a period of not less than twelve and not more than twenty-four months from the date hereof, any physician, practitioner, health care provider, hospital, health care institution, medical organization, clinic and any other medical or medically related facility, any insurance company or reinsurance company, workers compensation board or similar plan or organization, benefit plan administrator, federal, territorial or provincial government department, or any other corporation or organization, institution or association (including obtaining information from the group policyholder or my employer) to release and exchange with AIG Commercial Insurance Company of Canada, or representatives thereof, all personal health information and benefit payment information about me or any other information or records about me in its possession that is requested while administering my claim.

I agree that a reproduction of this authorization shall be as valid as the original.

Date : _____ Claimant's signature : _____

ASSIGNMENT OF BENEFITS

I, _____ HEREBY ASSIGN BENEFITS PAYABLE FROM THIS CLAIM TO AXIS INSURANCE MANAGERS INC. AND AUTHORIZE PAYMENT DIRECTLY TO THEM.

DATE SIGNATURE OF CLAIMANT
SEE ATTACHED FOR PHYSICIAN'S STATEMENT PLEASE ATTACH ALL ORIGINAL INVOICES OR RECEIPTS



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(B) YOUR PHYSICIAN MUST COMPLETE THIS SECTION IF CLAIMING FOR HOSPITAL, MEDICAL EXPENSES OR PHYSICIAN SERVICES

PHYSICIAN ACCOUNT RECORD COMPLETE

Diagnosis (describe complications, if any) and Procedures - Use exact wording of schedule of fees _____

Service Code	Fee Submitted	Number Of Services	Service Date M / D / Y	Diagnostic Code	Service Code	Fee Submitted	Number Of Services	Service Date M / D / Y	Diagnostic Code

Your total charge for these visits - at office \$ _____ Hospital \$ _____ Home \$ _____ TOTALS \$ _____

I DECLARE THAT THE ABOVE IS A CORRECT STATEMENT OF SERVICES PERSONALLY RENDERED BY ME.

SIGNED THIS: _____ DAY OF _____ 20_____ AT _____

PHYSICIAN'S NAME: _____

ADDRESS: _____

PHYSICIAN'S SIGNATURE: _____

MD () Certified Specialist? () _____ TELEPHONE NUMBER () _____

(C) DENTAL - IF YOU SUSTAINED DENTAL INJURY AS THE RESULT OF AN ACCIDENT AND ARE CLAIMING ACCIDENT RELATED DENTAL EXPENSES, PLEASE PROVIDE THE FOLLOWING:

DATE OF ACCIDENT: _____ DATE OF INITIAL DENTAL TREATMENT: _____

Please attach a standard dental claim form, available in your dentist's office, fully completed and signed by your dentist for the accident related dental treatment received.

FULL DETAILS OF ACCIDENT: _____

WHAT INJURIES WERE SUSTAINED: _____

How to Claim Studentsure Benefits

Before completing the form ...

1. If you are claiming expenses for your spouse and your spouse is covered for those expenses under another medical plan, you should submit the claim to your spouse's plan first.
2. You do not have to submit a claim every time an expense occurs except for out-of-country claims. You may hold your expense receipts until they represent a significant amount.
3. The deadline for submitting claims to Axis Insurance Managers Inc. is no later than 90 days, or before the expiry date of the policy. In the event of reasonable and justifiable cause, an extension will be granted, but in no event later than one (1) year after the date of the loss.
4. You must send out of country claims to us within 30 days of our return home. If you have a question about an out-of-country claim, call Axis Insurance Managers Inc. at 1-877-988-7873.

After completing the form ...

1. Please make sure that you have filled in all the information completely and signed the form. Incomplete forms will delay the processing of your claims.
2. Attach original receipts for expenses and keep copies for your records. We will not return original receipts. If any expenses have been submitted previously under another plan, attach the original Explanation of Benefits form for that plan and copies of the receipts.
3. Receipts should include the following:
 - Patients name
 - Nature of the treatment, medical product, or diagnosis
 - Name of prescribing physician
 - Amount charged
 - Date
4. Attach a written statement from the referring doctor if you are claiming for certain medical services or expenses such as medical equipment or nursing services. The written statement should confirm why the services were medically necessary and how long the services were needed.
5. Mail the completed form to:

**Axis Insurance Managers Inc.
Health Claims Office
107-1965 West 4th Ave
Vancouver, BC V6J 1M8**