



PROVINCIAL / MEDICAL INSURANCE CLAIM FORM

American Home Assurance Company
 145 Wellington Street West,
 Toronto, Ontario M5J 1H8
 Tel.: (416) 596-3000 Fax: (416) 596-4067
 Wats: 1-800-387-4481 Website: www.aig.com

Policy # SRG 9028300

PLEASE PRINT

Name of School _____		
Student's Name _____	(Last Name)	(First Name)
		SEX <input type="checkbox"/> Date of Birth: D M Y
Full Address in Canada _____		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	Nature of Illness or Injury	Claim Description	Amount Charged	Name of Doctor Prescribing Service

MEDICAL AUTHORITY

I hereby certify that the above information is true and complete to the best of my knowledge and belief. I authorize the release to American Home Assurance Company and its reinsurers all information requested with respect to my claim. A copy or photocopy 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 Winram Insurance and authorize payment directly to them.

_____ Date _____ Signature of Claimant

For Plan Administrator Use Only

For completion by Plan Administrator

POLICY NUMBER	COVERAGE EFFECTIVE DATE	COVERAGE IN FORCE	EMPLOYEE ONLY <input type="checkbox"/>	EMPLOYEE & DEPENDENT <input type="checkbox"/>
IF COVERAGE HAS TERMINATED GIVE DATE	DATE SIGNED	SIGNATURE OF PLAN ADMINISTRATOR		

PLEASE ATTACH ALL ORIGINAL INVOICES OR RECEIPTS
 SEE REVERSE SIDE FOR PHYSICIAN'S STATEMENT

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

PHYSICIAN ACCOUNT RECORD COMPLETE

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

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

Your total charges 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: _____ CITY _____ PROV. _____ POSTAL CODE _____

MD Certified Specialist? Tel: () _____ - _____

(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 ATTENTION: _____

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:

Date : _____ Claimant's Signature: _____

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 Winram Insurance 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 Winram Insurance 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**
 - **Date**
 - **Amount charged**
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:

**Winram Insurance
Health Claim Office
1108 West 8th Avenue
Vancouver, BC, Canada
V6H 3Z5**