GlobalExcel®

International Student Health and Hospitalisation Insurance

ROYAL & SUNALLIANCE

Claim Form

Section 1 PRINCIPAL INSURED'S INFORMATION

Certificate No.: | Date of birth (D/M/Y): / /

Last Name: | First Name:

Address : | Apt.: | City:

Province: | Postal Code: | Phone Number: ( )

1. Do you have health benefits or services provided under any other health plan? ❒ yes ❒ no

2. Name of the other insurance company: _____ or ❒ Government Health Insurance Plan

3. Policy or Certificate Number: _____

If the claim is for a dependent, please provide:

Last Name: | First Name: | Date of Birth (D/M/Y): / /

❒ **If you want this claim to be paid to the provider, please sign here:** ✍

❒ **If you have paid this claim** (include an original receipt), **please sign here:** ✍

Section 2 TO BE COMPLETED BY THE PROVIDER OF SERVICES

Physician's Name: | Phone Number: ( )

Clinic / Hospital:

Address:

City: | Province : | Postal Code:

DIAGNOSIS or **DIAGNOSTIC CODE** (please print): _____

In the case of a pregnancy, indicate date of last menstrual cycle (D/M/Y): _____

Service Date (e.g.: April 9, 2005)	**Description of Services**	**Service Code**	**Fees**
Physician's signature: ✍		Total:	

Section 3 MEDICAL AUTHORIZATION

The insured person must sign the medical authorization for all claims.

I understand that Royal & Sun Alliance Insurance Company of Canada and Global Excel Management Inc. may investigate my claim. By signing this application, I also hereby direct and authorize any physician, health care practitioner, hospital or other medical care facility, pharmacy, the Ministry of Health or any other person who has attended and examined me or who has knowledge or records of me or my health, to furnish to Royal & Sun Alliance Insurance Company of Canada and to Global Excel Management Inc. any or all information with respect to my sickness, injury, medical history, consultations, medicines or treatment and copies of all hospital or medical records for the purpose of investigating my claim.

Insured Person's signature: ✍ _____ Date (D/M/Y):_____/_____/_____

Cheque number :	Date:	Claim Number: