

CONCORDIA UNIVERSITY INTERNATIONAL STUDENTS CLAIM FORM EXTENDED HEALTH CARE BENEFITS

PO Box 3300, Station B, Montreal (Quebec) H3B 4Y5

	NEW ADDRESS*								
	NAME								
	ADDRESS		APT#						
			POSTAL CODE						
NAME OF PARTICIPANT	CONTRACT NO.	SECTION NO.	STUDENT ID						
* PLEASE FILL OUT THIS FORM AND ENCLOSE ORIGINAL COPIES OF YOUF DUPLICATES SHOULD BE RETAINED FOR YOUR FILE.	BILLS AND RECEI	PTS. THESE DO	CUMENTS WILL NOT BE RETURNED.						
WERE EXPENSES INCURRED FOLLOWING AN ACCIDENT? USS	□ NO IF YES	S, PLEASE SPEC	DIFY:						
DATE:PLAG	DE:								
- INDICATE WHY YOU RECEIVED MEDICAL AND/OR HOSPITAL CARE:									
DESCRIBE THE SERVICES RECEIVED (EX.: EXAMS, X-RAYS, SURGERY, ET	C.) IF NECESSARY,	CONTINUE ON	A SEPARATE PIECE OF PAPER.						
BEFORE DEPARTURE, DID YOU SEE A DOCTOR OR A SPECIALIST?	∕ES □ NO								
F YES, DATE OF LAST VISIT:NATURE OF ILLNESS:									
ARE EXPENSES SUBMITTED COVERED BY ANY OTHER INSURANCE CONT	RACT?	☐ YES	□ NO						
IS YOUR SPOUSE COVERED UNDER ANOTHER HEALTH INSURANCE PLAN	?	☐ YES	□ NO						
IF YES:									
CONTRACT NUMBER	INSURER'S NAME								
N.B.: THE SPOUSE WHO IS COVERED BY ANOTHER HEALTH INSURANCE PLAN MUST FIRST SUBMIT THEIR CLAIM TO THEIR INSURER. AFTERWARDS, PROVIDE MEDAVIE BLUE CROSS WITH A COPY OF YOUR RECEIPTS WITH A DETAILED ACCOUNT OF BENEFITS PAID. CLAIMS FOR CHILDREN MUST BE SUBMITTED TO THE INSURER OF THE PARENT (FATHER OR MOTHER) WHOSE BIRTHDAY OCCURS FIRST IN THE CALENDAR YEAR.									
I hereby certify that the expenses submitted were incurred following an illness	or injury and that r	my statements a	re true and complete.						
If the claim is submitted on behalf of my spouse or dependent children, I conf for the purpose of claim processing.	rm that I am author	rized to release	any information regarding the latter						
I authorize Medavie Blue Cross to obtain and use all pertinent information rele	evant to the claim p	rocessing and tl	ne administration of the plan.						
I authorize any person or organization, including health care providers or any respect of this claim, to release and exchange the information that is requested									
I understand that my personal information will be kept confidential and secure	-	•							
I understand that a photocopy or electronic version of this authorization is as	valid as the original	l.							
Signature	_								
A photocopy of this authorization shall be as valid as the original. This conse		deral and provinc	cial privacy laws.						

IF YOU ARE CLAIMING FO LOWING INFORMATION:	OR A DEPE	NDENT (CHILD (A	GED 18 (OR 21 AND OVER	BUT UNDER 25)	PLEASE PRO	VIDE THE FOL-
GIVEN NAME			NAME OF SCHOOL, COLLEGE OR UNIVERSITY BEING ATTENDED			SEMESTE	ER FULL	
PLEASE INDICATE THE TO	OTAL AMOL	JNT SUE	MITTED	FOR EA	CH PATIENT, PER	CALENDAR YEA	AR.	
GIVEN NAME	ZEN NAME DATE C		RTH YY	SEX	RELATIONSHIP	AMOUNT SUBMITTED	CALENDAR YEAR	FOR MEDAVIE BLUE CROSS USE ONLY
								302 31121
					TOTAL			