Mail to: The Campus Trust
101-33 Pippy Place
St. John's, NL A1B 3X2
Phone: 1-888-404-6623
Email: studentbenefits@pbas.ca

ASSIGNMENT OF BENEFITS FORM

THIS FORM IS AN ASSIGNMENT OF BENEFITS FORM, ALL PAYMENTS ARE MADE TO THE PROVIDER NOTED BELOW ON THE MEMBERS BEHALF.

Provider Name	Telephone Number

Mailing Address No. And Street	City	Province	Postal Code

TO BE CONSIDERED AN ELIGIBLE EXPENSE, CLAIMS MUST BE RECEIVED WITHIN 6 MONTHS FROM THE DATE EXPENSE WAS INCURRED OR THE DATE YOUR PLAN TERMINATED USING THE DATE OF SERVICE OR THE DATE SUPPLIES WERE PURCHASED. THIS FORM MUST BE COMPLETED IN FULL.

Name of University or College Student Organization	Policy Number	Student I.D. Number
Cape Breton University Students' Union	**663**	

Student Name	Date of Birth			Email Address
	D	M	Y	

Patient Information

Patient Name (if different than above)	Date of Service			Service Provided	Student Approval (Please initial)	Amount Charged
	D	M	Y			

PLEASE ATTACH INVOICE AND DOCTOR REFERRALS, IF APPLICABLE. PHOTOCOPIES ARE ACCEPTED. **Total Charged:**

In signing this Assignment of Benefits Form, I hereby authorize The Campus Trust to pay the above noted provider directly on my behalf for any expenses noted above and I certify that the charges for the medical supplies or services which the invoices are attached were incurred by myself or one of my eligible dependants upon recommendation and approval of the attending physician (if required under the terms of the Plan Text or where applicable) and required in connection with the treatment of accidental bodily injury or sickness of myself or one of my eligible dependant.

AUTHORIZATION: On behalf of myself and my eligible dependants, I authorize the Cape Breton University Students' Union and group benefit provider, The Campus Trust and any of its affiliates or re-insurers to exchange the personal information contained on this form or any other benefit related personal information contained in their files now or in the future respecting me or any of my eligible dependants. I give my consent on the understanding that the information will be used solely for purposes of administration and management of my group benefit plan. This consent shall continue so long as I and my dependants are covered by, or are claiming benefits under the present group contract, or any modification, renewal or reinstatement thereof. I further agree that a photocopy or electronic copy of this authorization is as valid as the original.

Date _____ Signature of Student _____ Telephone Number _____