Medical Care Claim for International Students

All claims must be submitted to Securian Canada at the address below no more than TWELVE MONTHS following the date on which the expenses are incurred.

Claimants must provide a valid Canadian address for reimbursement. Claimant reimbursement cheques will not be issued to a non-Canadian address.

Please PRINT clearly.

1. Member information

Member identification number		Policy number **017882**	Plan sponsor **The Campus Trust**
Last name		Middle name	First name
Date of birth (dd-mm-yyyy)	Sex ☐ Male ☐ Female	Telephone number	Email address
Canadian address (street number and name)			Apartment or suite
City		Province	Postal code

2. Complete this section if you or your spouse are covered under another plan

Are you also a member of another benefit plan? ☐ Yes ☐ No If yes, please provide details below.

Type of coverage ☐ Single ☐ Family	Are you claiming any expenses that are **not** covered under your other plan? ☐ Yes ☐ No If yes, please specify:	
If your other benefit plan is with Securian Canada, do you want us to process the claim through both benefit plans? ☐ Yes ☐ No	Contract number	Member ID number

Respecting your privacy

Respecting your privacy is a priority for Securian Canada. We collect information from application forms and other information you provide to us or our distribution partners in connection with insurance and/or financial products offered by us, as well as (with your consent) through independent medical or vocational assessments, if applicable, and from physicians, medical practitioners, hospitals, clinics or other medical or medically related facilities, insurance companies, MIB, LLC. ("MIB"), and other agents, governments agencies or other organizations, institutions, or persons that have health records, if applicable. We collect, use and disclose your personal information for purposes that include: confirming your identity, underwriting, including determining your eligibility or need for insurance and/or financial products you request; administration and servicing; claims adjudication; protecting against fraud, errors or misrepresentations; and meeting legal, regulatory or contractual requirements. We, and our affiliates, may use the personal information for the purpose of offering you, or allowing select organizations to offer you, other products and services. You may withdraw your consent for this purpose at any time by phone at: 1-888-968-4155 or by mail at: Privacy Office, 25 Sheppard Avenue West, Suite 1400 Toronto, ON M2N 6S6. We will give access to your personal information only to those of our employees and independent contractors, affiliates within our corporate group, administrators, distribution partners, and other third-party service providers and outsourcers, along with our reinsurers, who need your personal information to do their jobs. We will also provide access to anyone else you authorize. All of our service providers with whom we have a contractual relationship are required to protect your personal information in accordance with this privacy statement and our privacy practices. Sometimes, unless we are otherwise prohibited, these people may be in, or your personal information may be stored on servers located in, other provinces in Canada or in countries outside Canada, so your personal information may be subject to the laws of those other provinces or countries. You can ask for the information in our files about you and, if necessary, ask us in writing to correct it. To find out more about our privacy practices, visit *www.securiancanada.ca/privacy-code*

Questions? Please visit **www.securiancanada.ca** or call our toll-free number 1-888-206-9004

Securian Canada is the brand name used by Canadian Premier Life Insurance Company and Canadian Premier General Insurance Company to do business in Canada. Policies are underwritten by Canadian Premier Life Insurance Company and Canadian Premier General Insurance Company.

3. Information about your claim

List the names of all persons for whom you are claiming expenses. Add up all the receipts and insert the total amount claimed. Ensure each receipt clearly indicates the type of expense being claimed.

Attach **ORIGINAL** receipts indicating that you have paid the provider in full (photocopied bills/receipts are not acceptable).

Person for whom you are making the claim		Date of birth (dd-mm-yyyy)	Relationship to you	Full-time student	Disabled	Amount claimed
Last name	First name			☐ Yes ☐ No	☐ Yes ☐ No	$
Last name	First name			☐ Yes ☐ No	☐ Yes ☐ No	$
Last name	First name			☐ Yes ☐ No	☐ Yes ☐ No	$
Last name	First name			☐ Yes ☐ No	☐ Yes ☐ No	$
						Total claimed $

Are you attaching receipts for out-of-Canada expenses? ☐ Yes ☐ No

If yes, tell us the date of departure from claimant's home province. Ensure the currency and amount are clearly marked on each receipt. We'll assess your claim and convert the eligible expenses to Canadian dollars.

Date (dd-mm-yyyy)	Out-of-Canada expenses claimed
	$

Are any of the expenses you're claiming the result of a work injury? ☐ Yes ☐ No

If yes, did you submit your claim to the workers' compensation plan in your province, if applicable? ☐ Yes ☐ No

Are any of the expenses you're claiming the result of a motor vehicle accident? ☐ Yes ☐ No

If yes, did you submit your claim to the automobile insurance plan in your province, if applicable? ☐ Yes ☐ No

4. Authorization and signature

I certify that all goods and services being claimed have been received by me and/or my spouse or dependents, if applicable. I certify that the information in this form is true and complete and does not contain a claim for any expense previously paid for by this or any other plan.

If this claim is being made on behalf of my spouse and/or dependents, I am authorized to disclose information about them, for the purposes of underwriting, administration and adjudicating claims. I confirm that my spouse and/or dependents, if any, also authorize Canadian Premier Life Insurance Company ("Securian Canada") to disclose information about their claims to me, for the purposes of assessing and paying a benefit, if any, and managing my group benefits plan.

I authorize Securian Canada and its reinsurers to collect, use and disclose information about me, and if applicable, my spouse and/or dependents needed for underwriting, administration and adjudicating claims under this Plan to any other organization who has relevant information pertaining to this claim including health professionals, institutions, investigative agencies and insurers. I also understand that information pertaining to this claim may be reviewed in the event this Plan is audited.

In the event there is suspicion and/or evidence of fraud and/or Plan abuse concerning this claim, I acknowledge and agree that Securian Canada may investigate and that information about me, my spouse and/or dependents pertaining to this claim may be used and disclosed to any relevant organization including regulatory bodies, government organizations, medical suppliers and other insurers, and where applicable my Plan Sponsor, for the purpose of investigation and prevention of fraud and/or Plan abuse.

If there is an overpayment, I authorize the recovery of the full amount of the overpayment from any amount payable to me under my benefit plan(s), and the collection, use and disclosure of information about this claim to other persons or organizations, including credit agencies and, where applicable, my Plan Sponsor for that purpose.

I agree that a photocopy or electronic version of this authorization shall be as valid as the original, and may remain in effect for the continued administration of this Plan.

Any reference to Canadian Premier Life Insurance Company or the Plan Sponsor includes their respective agents and service providers.

Important

Check one of the following boxes:

☐ Payment is to be made to the member.
☐ Payment is to be made directly to the provider.

Claimant's signature	Date (dd-mm-yyyy)
X	

5. Provider information

Section 5 and 6 is to only be completed by the provider when reimbursement is to be made directly to provider.

Provider's name	Physician's name	
Address of provider (street number and name)		Apartment or suite
City	Province	Postal code
Provider ID number	Telephone number	

6. Statement of services (Physicians and hospitals must provide the diagnosis.)

Service date (dd-mm-yyyy)	**Description of service**	**Provincial procedure code** (plus time units, if applicable)	**Charge**	**Diagnosis**

I declare that the above is a correct statement of the services rendered.

Provider's signature	Date (dd-mm-yyyy)
X	

Direct all claims and inquiries to:

Securian Canada
PO Box 963 Stn A,
Toronto, ON, Canada M5W 1G5

Toll free: 1-888-206-9004, Monday - Friday 8:30am - 8pm ET.
You must provide your member ID when contacting us by telephone.