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

STATEMENT OF EXPENSES FOR HEALTH CARE BENEFITS

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. YOUR CLAIM FORM MUST BE COMPLETED IN FULL.

Name of University or College Student Organization	Policy Number	Student I.D. Number
MSVU Students' Union	**655**	

Student Name	Date of Birth (D M Y)	Email Address

Mailing Address No. and Street	City	Province	Postal Code

Coordination Of Benefits

Do you have another plan that provides Benefits for you or dependants? Yes ☐ No ☐

If yes, indicate:
- Name of the Insurance Provider — Policy Number
- Type of Coverage — Health Only ☐ Dental Only ☐ Both ☐
- Policyholder's Name (if applicable): — Date of Birth:

Patient Information				Drug Expenses		Other Expenses	
Patient Name	Date of Birth D	M	Y	DIN or Drug Name	Total Charge	Type Of Expense	Total Charge
				Total:	$0.00	Total:	$0.00

PLEASE ATTACH RECEIPTS AND DOCTOR REFERRALS*, IF APPLICABLE. PHOTOCOPIES ARE ACCEPTED.

In signing this Statement of Expenses, I certify that the charges for the medical supplies which are listed above and for which the bills 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 Policy or where applicable) and required in connection with the treatment of accidental bodily injury or sickness of myself or one of my eligible dependants. I declare that my statements in this expense reimbursement request are accurate and true. I also authorize the exchange of information with Healthcare providers (medical practitioners, dentists, pharmacists), MDM (your third party payer of drug claims) and with other insurance companies for COB purposes.

On behalf of myself and my eligible dependants, I authorize the Mount Saint Vincent University Students' Union, The Campus Trust, and any of its affiliates or re-insurers to collect, use and disclose personal information with the various parties for purposes of administering the group benefits plan for 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 agree that a photocopy or electronic copy of this authorization is as valid as the original.

Date _____ Signature of Student _____ Telephone Number _____