## International Student Medical Claim







**Claims at** TuGo, 10th Floor, 6081 No.3 Road Richmond, BC Canada V6Y 2B2

Tel: 604-278-4108 Fax: 604-276-4593 Canada & USA Toll Free: 1-800-663-0399

Claim No.	
For office use only	

	(Please print clearly. T	his form will be returned if not co	mpleted in full.)			
Name of the Insured c	e Insured claiming FIRST NAME LAST NAME O M					
Address						
	Prov					
Telephone()		E-mail				
Date of birth	MM   DD   YYYY	Country of residence				
Arrival date in Canada	MM   DD   YYYY	Planned departure	Planned departure date from Canada MM   DD   YYYY			
Travel insurance polic	y no	Effective date	Effective date MM   DD   YYYY			
· · · · · · · · · · · · · · · · · · ·	in with the first medical treatment in C		, ,	,		
	ury treated/medical diagnosis, date of		st of treatment and drugs  Cost of Treatment			
Date of Treatment (eg.) Jan 1 2015	Sickness/Injury & Service Provided  Rash on arm—consultation	Attending Physician's Name  Dr. Jones	\$55	Drugs Prescribed Fucidin		
(09.) 00.1 2 2020			755			
Date of admission  3. Have you been trea If "Yes", please pro	rnight: Name of hospital MM   DD   YYYYY  ated for the listed sickness(es) before the date(s) and place(s) of prevention and phone number	Date of discharge _ re? O Yes O No rious treatment	MM	DD   YYYY		
,	ny prescribed drugs or medications the names of these drugs or medic			O No		
6. Are you covered ur	nder any other medical insurance pl	lan, either private or provincial	/government? O Ye	s O No		
Name of plan	Plan, policy	or contract no	Effective	e dateMM   DD   YYYY		
7. If you prefer that re your signature as a	eimbursement be made payable to s authorization.	someone other than yourself, p	olease print their name	e below, and provide		
Name of payee		Relationship to Insu	ured			
X Signature of Incured			 Date	M DD YYYY		

## FAILURE TO PROVIDE ALL INFORMATION REQUESTED IN THIS FORM AND SIGNED MEDICAL AUTHORITY MAY CAUSE EXTREME DELAYS IN PROCESSING YOUR CLAIM.

Please ensure that this completed form is returned promptly to Claims at TuGo with signed Medical Authority.

## MEDICAL AUTHORITY

## Authorization to physicians, hospitals, other medical providers & other insurers

- 1. I authorize all hospitals, physicians, medical care providers, insurers and other persons, from all countries, to provide to Claims at TuGo all information and documentation in their possession that Claims at TuGo requires to process my claim, including: records in regard to illnesses, injuries, medical history, consultations, medicines and treatments of the claimant named below (collectively, the "Medical Records") and other applicable insurance policy information.
- 2. I authorize Claims at TuGo to collect, use and disclose the Medical Records, and the information in the Medical Records, to the selling agent, and to any insurers, including government health plans, that may have a responsibility in this claim.
- 3. I understand that the purpose for the collection, use and disclosure of the Medical Records and other insurance policy information is to enable Claims at TuGo and insurers to assess and determine the eligibility of and other available insurance for any claim I might submit. I acknowledge and agree that it is my responsibility to provide to Claims at TuGo such information and other documentation as may reasonably be required to process my claim and that my failure to do so will jeopardize my entitlement to coverage.
- 4. I understand that if Medical Records are required from the U.S., this purpose constitutes a payment operation under the privacy rules in the U.S. Health Insurance Portability and Accountability Act.
- 5. This authorization takes effect on the date set out below. I understand that I may revoke this authorization in writing. I acknowledge and agree that if this authorization is revoked before the Medical Records are collected and reviewed my entitlement to insurance coverage will be jeopardized.

A copy of this authorization received from Claims at TuGo shall be as effective and valid as the original.

FIRST NAME LAST NAME
Print name (and relationship if not claimant)

X
Signature (Claimant or authorized representative)

MM | DD | YYYY | Date