GlobalExcel
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UNB
UNIVERSITY OF NEW BRUNSWICK

CLAIM FORM

IMPORTANT: You must complete all sections of the form so the evaluation of the claim can proceed without delay. It may be returned to you if the information is incomplete or incorrect.

A – TO BE COMPLETED BY INSURED

Name of Group: **UNIVERSITY OF NEW BRUNSWICK** ☐ **Fredericton** Campus ☐ **Saint John** Campus	Policy Number: **ISHNB001**	Student ID Number:
Student Last Name:	Date of Birth (D/M/Y):	
Student First Name:	E-mail:	
Address:	Apt.:	
City, Province: Postal Code:	Telephone:	

If this claim is for your spouse or child, please provide:

Dependant Last Name: _____ Dependant First Name: _____

Date of Birth (D/M/Y): _____/_____/_____

Do you have health benefits or services provided under any other health plan (including Government Health Insurance Plan)? ☐ yes ☐ no

Name of the insurance company: _____ Policy or Certificate # _____

Is this reimbursement request the result of an accident? If yes, please provide details (date, type, circumstances): _____

_____

DO YOU WANT THIS CLAIM TO BE PAID TO THE PROVIDER OF SERVICES? ☐ YES ☐ NO

B – TO BE COMPLETED IF COSTS ARE INCURRED IN THE PROVINCE OF NEW BRUNSWICK

In the case of a PREGNANCY, indicate the date of last menstrual cycle (D/M/Y): _____

Service Date (e.g.: Sept 1, 08)	**DIAGNOSIS (and/or Diagnostic Code) and DESCRIPTION OF SERVICES (and/or Service Code)**	**Charges/Fees**
		$
		$
		$

Physician's signature: _____
(Only required if physician submits for direct reimbursement from Global Excel.)

NOTE TO THE PROVIDER OF MEDICAL SERVICES: Fax this signed form to Global Excel at 1-877-955-8466 for prompt reimbursement.

Name of Physician: _____ Telephone: _(_____)_____

Clinic/Hospital: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

C – AUTHORIZATION AND RELEASE – TO BE SIGNED BY INSURED

1. I understand that Global Excel Management Inc. may investigate my claim. By signing this claim form, I also hereby direct and authorize any physician, healthcare practitioner, hospital or other medical care facility, pharmacy, the Ministry of Health or any other person who has attended and examined me or who has knowledge or records of me or my health, to furnish to Global Excel Management Inc. any or all information with respect to my sickness, injury, medical history, consultations, medicines or treatment and copies of all hospital or medical records for the purpose of investigating my claim.
2. I assign to Royal & Sun Alliance Insurance of Canada and to Global Excel Management Inc. any indemnity obtainable from other sources for covered losses under this policy. I also direct these sources to forward payment to Global Excel Management, Inc. for my claims submitted by Global Excel Management Inc. with regard to these losses and to exchange information that facilitates this process.
3. I understand that my insurance shall be void if, whether before or after the loss, any person has concealed or misrepresented any fact or circumstance concerning this claim.

_____
Insured's signature **Date** (D/M/Y)

If this claim concerns costs incurred during a stay outside the province of New Brunswick, please complete the back of this form.

Global Excel Use Only	Cheque #:	Date:	Claim #:

D – TO BE COMPLETED IF COSTS WERE INCURRED DURING A STAY OUTSIDE THE PROVINCE OF NEW BRUNSWICK

Reason for trip: ☐ vacation ☐ co-op work term ☐ country of origin ☐ other, please specify: _____

Date of departure (D/M/Y): _____ Date of return (D/M/Y): _____

Please include a proof of travel dates (ex.: copy of passport, airline tickets or other).

Medical services received – Please indicate the reason you received medical treatment (diagnosis, nature of the sickness or injury):

_____

Describe the medical treatment received (ex.: consultations, diagnostic services, surgery, etc.). If space is insufficient, please attach another sheet of paper.

_____

_____

In what city and country were the services received? _____

If this claim is related to an accident, please provide details (date, type, circumstances):

_____

_____

Claimed Amount: $_____ ☐ Canadian ☐ Other, please specify: _____ You will be reimbursed in Canadian currency, at the exchange rate on the date you are reimbursed.	Have the bills been paid? ☐ yes ☐ no ☐ in full ☐ in part ► $ _____

IMPORTANT INFORMATION

- Send only originals of all bills or receipts (copies are not acceptable). Originals will not be returned to you. As such, please conserve copies for your files.
- Only providers of medical services who have agreed to bill Global Excel directly can submit a claim form by fax, under the condition that the form is completed and signed by the insured and the physician.
- Billed charges by a physician to complete a claim form are not reimbursable.
- All claim forms must be signed by the insured person.

Send your claim form and your original bills or receipts to:

Global Excel Management Inc.
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