# Student VIP International Short Term Coverage Application Form

I am a: ☐ Visiting Researcher ☐ Visiting Scholar ☐ ESL Student ☐ Other:_____

Please indicate which Faculty/Department/Program you're part of: _____

## Applicant Information

First Name: _____ Last Name: _____

Student ID: (if available) _____ Date of Birth: DD / MM / YY Sex: ☐ Male ☐ Female ☐ Prefer Not To Say

Home Country: _____ E-mail: _____

Please indicate which school you are currently registered at: ☐ Dalhousie ☐ Saint Mary's

## Contact Information for Home Country Physician:

Physician Name _____

Address _____

Email: _____ Phone Number ( )

## Coverage Requirements *(minimum charge of $20.00/single, $55.00/family)*

☐ Single (2.10/day) ☐ Family ($2.90/day for 1st dependent) ($1.85/day for each additional dependent)

*If Family Coverage is required, please complete back of sheet*

| # Days Required | Rate | Amount Owing |
|---|---|---|
| | $_____/day | $ |

Arrival/Start Date: DD / MM / YY Departure/End Date: DD / MM / YY

## Payment Details: ☐ Credit Card ☐ Debit

Credit Card Number: _____ Expiry Date: _____

Name on Card: _____ CCID: _____

## Address In Canada

Address: _____

City: _____ Province: _____ Postal Code: _____

Name of Guardian (if applicable) _____ Phone Number: ( )

## Emergency Contact

In case of an emergency, I give permission to the following person to act on my behalf should I be unable to make my own medical decisions. In case of such an emergency, please contact:

Name: _____ Phone Number ( )

**PERSONAL INFORMATION NOTICE:** I understand that the information provided by me on this application is required by Medavie Blue Cross™ its re-insurers and authorized administrators (the "Insurer") to assess mine and/or my dependents entitlement to benefits.

**CERTIFICATION:** The statements I provide in completing this application are true and complete to the best of my knowledge and belief. In the event of a false or misleading statement in this application, coverage can be denied.

**AUTHORIZATION:** I authorize, for a period of not less than twelve and not more than twenty-four months from the date hereof, any physician, practitioner, health care provider, hospital, health care institution, medical organization, clinic and any other medical or medically related facility, any insurance company or reinsurance company, workers compensation board or similar plan or organization, benefit plan administrator, federal, territorial or provincial government department, or any other corporation or organization, institution or association (including obtaining information from the group policyholder or my employer) to release and exchange with Medavie Blue Cross™ or representatives thereof, all personal health information and benefit payment information about me and/or my dependents or any other information or records about me and/or my dependents in its possession that is requested while administering my claim. I agree that a reproduction of this authorization shall be as valid as the original.

Student Signature/ Parent/Guardian: _____ Date: _____

**Student VIP Office Use ONLY**

**Date Application Received:** _____ (Year / Mo. / Day) **Initials of Receiver:** _____ **Total Amount Paid:** _____

**Application:** ☐ Accepted ☐ Declined

**Reason if Declined:**

**Payment Method:** ☐ Debit ☐ VISA ☐ Master Card

## Eligible Dependent Information (use additional sheets if necessary)

Eligible dependents are identified as:

- Spouse/common-law partner of an Insured Student under the age of 65 and/or;
- Dependent Children

Only dependents who do not qualify for a Government Health Insurance Plan (GHIP) are eligible to be enrolled on this plan.

### Dependent 1

First Name: _____ Last Name: _____

Date of Birth: DD / MM / YY Sex: ☐ Male ☐ Female ☐ Prefer Not To Say

Relationship _____

### Dependent 2

First Name: _____ Last Name: _____

Date of Birth: DD / MM / YY Sex: ☐ Male ☐ Female ☐ Prefer Not To Say

Relationship _____

### Dependent 3

First Name: _____ Last Name: _____

Date of Birth: DD / MM / YY Sex: ☐ Male ☐ Female ☐ Prefer Not To Say

Relationship _____

### Dependent 4

First Name: _____ Last Name: _____

Date of Birth: DD / MM / YY Sex: ☐ Male ☐ Female ☐ Prefer Not To Say

Relationship _____