studentVIP Cowan

International Student Health Program Claim Form

Please e-mail completed claims to ISHP@cowangroup.ca

SECTION 1 – Insured Information - Who is the claim for		
Insured's Name (*Last Name, First Name*):		
Insured Student Number (as listed on plan card)	**Group Policy #:**	**Date of Birth (*dd/mm/yyyy*):**
If the insured has other health insurance, please list the insurance company name and policy number:		

SECTION 2 – Payment Information – Who is being reimbursed & how		
Name of person, health care provider or school to send payment to (*Please list name as Last Name, First Name):*	**Telephone:**	
	E-Mail:	
Payment by ☐ **EFT** Please attach a void cheque to this form. If not attached, all eligible reimbursements will be sent by cheque.		
Payment by ☐ **Cheque** Only complete the address section below if you wish to be reimbursed by cheque.		
Street Address:		**Apt.:**
City:	**Province:**	**Postal Code:**

SECTION 3 – Statement of Services – What receipts are you claiming reimbursement for			
Service Date	**Expense Type** (Medical, Drug,Dental,Vision, etc.)	**Reason for visit / expense**	**Invoice Amount** (If you have not paid, please fill out the provider information in section 2 for payment)

Please include all receipts/invoices that correspond with the chart. If receipts are missing this will delay your claim.

SECTION 4 – Authorization (*To be completed by Claimant or Legal Guardian when Claimant is under 18 years of age)*

I, the undersigned, authorize the Cowan Insurance Group ("*CIG*"), my employer, my plan administrator, physician, health care professional, hospital, medical facility, insurance company, workers compensation board or similar plan or organization, federal, territorial or provincial government department, or any other corporation or organization, institution or association, to release and exchange with CIG, or its representatives, all medical or benefit payment information or any other information or records in its possession that CIG may hold or request for the purposes of adjudicating this claim. I certify that the information I am submitting in support of my claim is true and complete to the best of my knowledge and belief. I understand that CIG may investigate my claim by collecting additional relevant personal information about me or my dependents from me and/or from other third parties. In cases of suspected fraud or plan abuse, CIG will investigate and I agree that CIG may share information with regulatory bodies, government or police agencies, healthcare professionals and the plan administrator or employer, if appropriate.
I agree that a photocopy of this authorization shall be as valid as the original.
I hereby authorize Cowan Insurance Group to make payment to the **Named Individual or Organization** indicated in section 2.

Date: _____ **Signature:** _____