Claim Form

studyinsured™

INSTRUCTIONS

IMPORTANT

- All claims must be reported to Intrepid 24/7™ within 30 days of occurrence.
- Written proof of claim must be submitted to Intrepid 24/7™ within 90 days of occurrence.
- You are responsible for all fees charged for any supporting documentation.
- Failure to complete and sign this form in its entirety or submit supporting documentation will delay claim processing.

CLAIMS SUBMISSION

- Complete all sections and ensure this form is signed before submitting to Intrepid 24/7™ with all invoices, physician and medical reports detailing treatment and treatment dates, and prescription pharmacy receipts. Keep copies for your records.
- Claimants must attach a copy of the emergency room report and all hospital records if treated at a hospital.

SECTION A: CLAIMANT

STUDENT

Last Name | First Name | Date of Birth (DD/MM/YYYY)

Policy Number | Group Number | ID Number | Enrollment Date (DD/MM/YYYY) | Arrival Date in Canada (DD/MM/YYYY)

☐ Male ☐ Female ☐ Non-binary ☐ Undisclosed | Educational Institution | Country of Origin

CLAIMANT'S ADDRESS WHILE IN CANADA

Unit # | Street Name and # | City | Province | Postal Code

Telephone | Mobile | Email

DETAILS OF FAMILY PHYSICIAN IN COUNTRY OF ORIGIN (IF AVAILABLE)

Full Name | Clinic Name or Practice

Unit # | Street Name and # | City | Country | Postal Code

Telephone | Fax

DETAILS OF TREATING PHYSICIAN IN CANADA

Full Name | Clinic Name or Practice

Unit # | Street Name and # | City | Province | Postal Code

Telephone | Fax

SECTION B: OTHER INSURANCE COVERAGE

Does the claimant currently have provincial or government coverage of any kind? ☐ Yes ☐ No

If yes, provide the name of the provincial or government agency providing coverage:

Is the claimant covered by another medical or travel insurance policy (including coverage through a spouse, parent, or guardian?) ☐ Yes ☐ No

If yes, please provide details of other insurance company coverage below.

Full Name | Insurance Company

Employer Name (if applicable) | Policy/Plan Number | Employer Group Number (if applicable) | ID/Certificate Number

Employer Phone (if applicable)

SECTION C: CLAIM INFORMATION

Description of claimant's sickness or injury (if this space is insufficient, additional information can be attached):

Date symptoms first appeared or injury occurred (DD/MM/YY):

Has the claimant ever been treated for this, or a similar or related, condition before? ☐ Yes ☐ No

Date claimant first saw a physician for this, or a similar or related, condition (DD/MM/YY):

Please provide all dates of treatment and list all medications taken for this, or a similar or related, condition before the effective date of the policy:

Treatment Date (DD/MM/YY)	Medication

SECTION D: EXPENSES CLAIMED

Name of Provider	Reason for visiting the doctor & Diagnosis	Date of Service (DD/MM/YY)	Amount Billed ($)	Amount Paid ($)

SECTION E: AUTHORIZATION AND CERTIFICATION

Markel Syndicate Management Limited ("Markel"), Intrepid 24/7™ ("Intrepid"), its agents, and administrators, are obliged to collect and retain certain personal and/or health information about you in connection with your insurance coverage. We use and disclose this information only for the purposes of administering your policy/policies of insurance, providing customer service, and in assessing and paying claims. We are committed to protecting the privacy, confidentiality, and security of the personal information we collect, use, retain, and disclose. Your personal information will be used only for the purposes of providing you with the requested insurance services. Markel's and Intrepid's complete privacy policies are available upon request.

I authorize any doctor, medical practitioner, hospital, facility providing medical or health-related services, third-party administrator, provincial plan, and any other insurer to release and exchange with Markel, Intrepid, or its representatives, any information (including personal health data and records) required to process this claim. I authorize any third party providing me with assistance in this claim process to have access to any and all relevant claims information related to the adjudication of my claim with Markel and Intrepid. I authorize Intrepid to coordinate the payment of benefits with any insurance carriers that may have a liability for this claim and assign to Markel and Intrepid any benefits payable from any other sources for losses covered under this policy, and authorize and direct such payers to forward payment directly to Markel and Intrepid. I confirm below by my signature that I am authorized to act on behalf of any of my dependants for these purposes. A photocopy of this authorization shall be as valid as the original.

I certify that the information provided in connection with this claim is complete, true, and accurate.

Full name of Insured (please print):

If Insured is a minor, full name of parent or legal guardian (please print):

Signature of Insured (if a minor <16, signature of parent or legal guardian)

Signature of policyholder of other insurance in Section B, if applicable

SECTION F: AUTHORIZATION TO PAY

This claim is payable to:

☐ Insured at the address in Section A above ☐ Parent/Guardian ☐ Hospital/Clinic ☐ Physician ☐ Other

If applicable, I authorize payment of this claim to (please print):

Date signed (DD/MM/YY):

IN THE EVENT OF AN EMERGENCY PLEASE CONTACT INTREPID 24/7™ IMMEDIATELY AT:

1.866.883.9787
toll-free from Canada and the USA

+1 416.640.7865
collect where available

e-mail: **intrepid@intrepid247.com**

CLAIMS SUBMISSION:

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