



INTERNATIONAL STUDENTS Claim Form

GlobalExcel®

IMPORTANT: When a medical emergency or hospitalization occurs, you must contact Global Excel within 48 hours of admission. Call **1-800-715-8833** or collect **(819) 566-8839**.

Policy / Certificate #: <small>(see your insurance card)</small>	Coverage (D/M/Y): / / to / /
Name of Insured:	Date of Birth (D/M/Y): / /

Make cheque payable to: <small>(Name and Address)</small>	Tel.: ()
	Fax: ()
	E-mail:

1. Do you have health benefits or services under any other plan? (Including government health plan) YES NO

Name of Other Insurance Plan: _____ Policy #: _____

2. Original bills and receipts must accompany this fully completed Claim Form for reimbursement to be made to the insured.

NOTE TO MEDICAL PROVIDERS: FAX this signed form directly to Global Excel for prompt reimbursement. If claim is for regular care of a chronic condition, have the insured pay for this visit. Questions? Please call # below.

Diagnosis: _____

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

Service Date <small>(ex.: April 9, 2006)</small>	Description of Service	Service Code	Fees

Rx given X-ray Ordered Lab work Ordered Follow-up(s): Other: _____

Is this claim related to an accident? YES NO Please provide details (date, location, circumstances)

Did the patient suffer the same symptoms or similar illness in the past? YES NO

Please provide details (date, symptoms, treatments):

Doctor's Name PRINT

Date (D/M/Y)

Dr.'s Signature (only required if Dr. submits for direct payment)

ATTACH ALL BILLS **and MAIL TO:**
Global Excel Management Inc.
73 Queen Street, Sherbrooke, Quebec Canada J1M 1J3
Tel.: 1-800-336-9224 or (819) 566-8698

MEDICAL PROVIDERS ONLY
Fax: 1-877-955-8466

This form can be copied
www.globalexcel.ca

Authorization and Release

- 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.
- I assign 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.
- 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.



Claimant's or authorized person's signature

Date (D/M/Y)

CHEQUE #:

DATE (D/M/Y):

CLAIM #: