Mail to: The Campus Trust
Suite 100, 61 International Boulevard
Toronto, Ontario, M9W 6K4
1 888 404 6623

STATEMENT OF EXPENSES FOR HEALTH CARE BENEFITS

TO BE CONSIDERED AN ELIGIBLE EXPENSE, CLAIMS MUST BE RECEIVED WITHIN 6 MONTHS FROM THE DATE EXPENSE WAS INCURRED OR THE DATE COVERAGE TERMINATED USING THE DATE OF SERVICE OR THE DATE SUPPLIES WERE PURCHASED. YOUR CLAIM FORM MUST BE COMPLETED IN FULL.

Name of University or College Student Association	Policy Number & Account
University of Prince Edward Island Student Union	**0940P001 P**

Student Name	Student I.D. Number	Date of Birth
		Day Month Year

Mailing Address No. and Street	City	Province	Postal Code

Do you have another plan that provides Health or Dental Benefits for you or dependents?	Yes □	No □	
If yes, indicate type of coverage:	Health Only □	Dental Only □	Both □
If yes, indicate the name of the Insurance Provider:	Policy Number		
If claim is for a dependant child, please indicate spouse's date of birth:			
If claim is for child indicate: Full-time Student □ Part-time Student □	Date Enrolled	Date Completed	
Is treatment a result of an occupational injury or otherwise related employment?	Yes □	No □	

Patient Names	First Name	Sex	Date of Birth D	M	Y	Date of Expense	Supplier Name	Drugs: Name or D.I.N. or Other Type of Expense	Amount

PLEASE ATTACH ALL ORIGINAL OFFICIAL RECEIPTS AND DOCTOR'S REFERRALS, IF APPLICABLE.

Total Charges $

☐ I certify that the charges for the medical supplies which are listed above and for which the bills are attached were incurred by myself or one of my eligible dependants upon recommendation and approval of the attending physician (if required under the terms of the Plan Text or Insurance Policy, where applicable) and required in connection with the treatment of accidental bodily injury or sickness of myself or one of my eligible dependants.

AUTHORIZATION: On behalf of myself and my eligible dependants, I authorize my Student Union and group benefit provider, The Campus Trust and any of its affiliates or re-insurers to exchange the personal information contained on this form or any other benefit related personal information contained in their files now or in the future respecting me or any of my eligible dependants. I give my consent on the understanding that the information will be used solely for purposes of administration and management of my group benefit plan. This consent shall continue so long as I and my dependants are covered by, or are claiming benefits under the present group contract, or any modification, renewal or reinstatement thereof.

Date _____ Signature of Student _____ Telephone Number _____