



GlobalExcel®

73 Queen Street  
Sherbrooke (Québec) J1M 0C9  
1 800-336-9224 or 819-566-8698



# CLAIM FORM

**IMPORTANT: You must complete all sections of the form so the evaluation of the claim can proceed without delay. It may be returned to you if the information is incomplete or incorrect.**

<b>A – TO BE COMPLETED BY INSURED</b>	
Name of Group: <b>UPEI STUDENT UNION</b>	Policy Number: <b>3481S002</b> Student Number:
Last Name:	Date of Birth (D/M/Y):
First Name:	E-mail:
Address:	Apt.:
City, Province:	Postal Code:      Telephone:
If this claim is for your spouse or child, please provide: Last Name: _____ First Name: _____ Date of Birth: ____/____/____ Do you have health benefits or services provided under any other health plan (including Government Health Insurance Plan)? <input type="checkbox"/> yes <input type="checkbox"/> no Name of the insurance company: _____ Policy or Certificate #: _____ Is this reimbursement request the result of an accident? If yes, please provide details (date, type, circumstances): _____ _____	
<b>DO YOU WANT THIS CLAIM TO BE PAID TO THE PROVIDER OF SERVICES?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO	

<b>B – TO BE COMPLETED IF COSTS ARE INCURRED IN THE PROVINCE OF PRINCE EDWARD ISLAND</b> In the case of a PREGNANCY, indicate the date of last menstrual cycle (D/M/Y): _____		
Date (e.g.: Sept 1, 08)	DIAGNOSIS (and/or Diagnostic Code) and DESCRIPTION OF SERVICES (and/or Service Code)	Charges/Fees
		\$
		\$
		\$
		\$
Physician's signature : _____ <i>(Only required if physician submits for direct reimbursement from Global Excel.)</i>		
NOTE TO THE PROVIDER OF MEDICAL SERVICES: Fax this signed form directly to Global Excel at 1-877-955-8466 for prompt reimbursement.		
Name of Physician: _____ Telephone: _(_____)_____		
Clinic/Hospital: _____		
Address: _____		
City: _____ Province: _____ Postal Code: _____		

<b>C - AUTHORIZATION AND RELEASE – TO BE SIGNED BY INSURED</b>	
<p>1. 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.</p> <p>2. 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.</p> <p>3. 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.</p>	
Insured's signature	Date (D/M/Y)

**If this claim concerns costs incurred during a stay outside the province of Prince Edward Island, please complete the back of this form.**

<b>Global Excel Use Only</b>	Cheque #:	Date:	Claim #:
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**D – TO BE COMPLETED IF COSTS WERE INCURRED DURING A STAY OUTSIDE THE PROVINCE OF PRINCE EDWARD ISLAND**

Reason for trip:  vacation  co-op or work term  country of origin  other, please specify: \_\_\_\_\_

Date of departure (D/M/Y): \_\_\_\_\_ Date of return (D/M/Y): \_\_\_\_\_

Please include a proof of travel dates (ex.: copy of passport, airline tickets or other)

Medical services received – Please indicate the reason you received medical treatment (diagnosis, nature of the sickness or injury):

Describe the medical treatment received (ex.: consultations, diagnostic services, surgery, etc.). If space is insufficient, please attach another sheet of paper.

In what city and country were the services received: \_\_\_\_\_

If this claim is related to an accident, please provide details (date, type, circumstances):

Claimed Amount: \$ \_\_\_\_\_

Canadian

Other, please specify: \_\_\_\_\_

You will be reimbursed in Canadian currency, at the exchange rate on the date you are reimbursed

Have the bills been paid?  yes  no

in full  in part ► \$ \_\_\_\_\_

**IMPORTANT INFORMATION**

- Send only originals of all bills or receipts (copies are not acceptable). Originals will not be returned to you. As such, please conserve copies for your files.
- Only providers of medical services who have agreed to bill Global Excel directly can submit a claim form by fax, under the condition that the form is completed and signed by the insured and the physician.
- Billed charges by a physician to complete a claim form are not reimbursable.
- All claim forms must be signed by the insured person.

**Send your claim form and your original bills or receipts to:**

**Global Excel Management Inc.  
73 Queen Street  
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