# HEALTH CARE CLAIM FORM

All claims must be submitted to Morcare at the address below within 6 months from the date on which the expenses are incurred or November 30th, 2024; whichever is earlier. Claimants must provide a valid Canadian address for reimbursement. Claimant reimbursement cheques will not be issued to a non-Canadian address.

**Please send your claim to the following email: claims@morcare.ca**

Secondary option via mail: Morcare Insurance, 2255 Sheppard Ave East, Suite 202, 2nd Floor, Atria 1, Toronto, ON M2J 4Y1

## SECTION 1A. STUDENT INFORMATION — PLEASE PRINT CLEARLY

Please provide the following information:

MORCARE — INTERNATIONAL STUDENT INSURANCE CARD

| | |
|---|---|
| LAST NAME | FIRST NAME |
| claimsecure 510000 — DRUG, DENTAL & EXTENDED HEALTH GROUP NUMBER | CERTIFICATE ID |
| iA Financial Group 100011335 — HOSPITAL, PHYSICIAN & ACCIDENT POLICY NUMBER | CERTIFICATE ID |
| DATE OF BIRTH | ☐ MALE ☐ FEMALE |

* Please refer to your Morcare Card

| | |
|---|---|
| TELEPHONE NUMBER | |
| EMAIL ADDRESS | |
| CANADIAN ADDRESS (STREET NUMBER AND NAME) | |
| APARTMENT / UNIT NUMBER | CITY |
| PROVINCE | POSTAL CODE |

## SECTION 1B. DEPENDENT INFORMATION (SPOUSE OR CHILD OF STUDENT) — PLEASE PRINT CLEARLY

**Complete this section only if you are submitting a claim for a dependent.**

List the names of all persons for whom you are claiming expenses. Add up all the receipts and insert the total amount claimed. Ensure each receipt clearly indicates the type of expense being claimed. Attach ORIGINAL receipts indicating that you have paid the provider in full (photocopied bills/receipts are not acceptable).

| LAST NAME | FIRST NAME | Gender | Date of birth (dd-mm-yyy) | Relationship to you | IF OVER 18 YEARS OF AGE: Full-time student | IF OVER 18 YEARS OF AGE: Handicapped child | Amount claimed |
|---|---|---|---|---|---|---|---|
| | | | | | ☐ YES ☐ NO | ☐ YES ☐ NO | $ |
| | | | | | ☐ YES ☐ NO | ☐ YES ☐ NO | $ |

## SECTION 2. INFORMATION ABOUT YOUR CLAIM — PLEASE PRINT CLEARLY

**Please describe the reason for your claim and your symptoms.**

For example: stomach ache, migraine, broken bone, fever, eye infection, eye glasses/contacts, massage therapy, prescription drugs, etc.

TOTAL AMOUNT OF CHARGES $

**Date first diagnosed with symptom(s) (dd-mm-yy):**

**Is your claim related to pregnancy?** ☐ **No** ☐ **Yes** **If yes, please provide due date (dd-mm-yy):**

**Is your claim the result of an accident?** ☐ **No** ☐ **Yes**
**If yes, please explain what happened:**

DATE OF ACCIDENT (DD-MM-YYYY)

**Is your claim related to any of the following?**

☐ **Co-op Work Placement for School**
(Attach co-op placement confirmation)

☐ **School Program (ECE, Nursing etc.)**
(Attach notice of medical requirements)

**Please carefully read this entire page if you are claiming medical expenses under your OHIP Alternative Coverage.**

Examples Include:

- Hospital visits/hospitalization
- Emergency room visits
- Walk in clinic
- Physician visit
- Ultrasound/x-rays
- Blood tests

## SECTION 3. PARAMEDICAL EXPENSES — PLEASE PRINT CLEARLY

This section to be completed if claiming for paramedical services, x-rays, or laboratory fees.

| Date service rendered (dd-mm-yyy) | Nature of illness or injury | Claim description | Amount charged | Name of Doctor prescribing service | Date first consulted for condition (dd-mm-yyy) |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

## SECTION 4. PHYSICIAN'S ACCOUNT RECORD (FOR THE COMPLETION BY THE PHYSICIAN) — PLEASE PRINT CLEARLY

Your physician must complete this section if claiming for hospital, medical expenses or physician services

| PHYSICIAN'S NAME | PROVIDER ID NUMBER | TELEPHONE NUMBER |
|---|---|---|
| | | |

| ADDRESS OF PROVIDER (STREET NUMBER AND NAME) | SUITE NUMBER | CITY | PROVINCE | POSTAL CODE |
|---|---|---|---|---|
| | | | | |

DATE PATIENT FIRST CONSULTED YOU WITH SYMPTOM(S) (DD-MM-YYYY)

| Service date (dd-mm-yyyy) | Description of service | OHIP Procedure code (plus time units, if applicable) | Charge | Diagnostic code |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**DIAGNOSIS** (DESCRIBE COMPLICATIONS, IF ANY) / **PROCEDURES** (USE EXACT WORDING OF SCHEDULE OF FEES)

**I declare that the above is a correct statement of the services rendered by me.**

**X** _____ _____

PHYSICIAN'S SIGNATURE (OR STAMP) DATE (DD-MM-YYYY)

## SECTION 5. AUTHORIZATION AND DECLARATION

PLEASE PRINT CLEARLY

### Industrial Alliance Insurance and Financial Services Inc.

**Medical Services under OHIP Alternative (eg. Hospital, Physician services, x-rays, blood tests, etc.)**

On behalf of myself, and/or spouse, and/or any minor insured, I RELEASE the information contained in this Claim Form to Industrial Alliance Insurance and Financial Services Inc. (the "Company") and ACKNOWLEDGE that this information will be used to assess, process and administer this claim and policy coverage.

I hereby authorize the Company, for the purposes of investigation, evaluation and administration of my claim:

a) to gather only the information necessary for the above specified purposes from any person or organization that has personal information relating to me, including other insurers, reinsurers, and financial institutions; physicians, medical institutions and healthcare providers; employers or administrators of group benefits; agents or brokers; investigating and credit reporting agencies, and all persons or organizations likely to have personal information relevant to my claim.

b) to disclose and exchange only the necessary personal information the Company has relating to me to the above persons and organizations.

I understand that the personal information obtained by the use of this authorization will be used by the Company in the investigation, administration and evaluation of a claim for benefits. Any information obtained will not be released by the Company, except to persons or organizations performing business or legal services in connection with my claim, or as may be otherwise lawfully required or as I may further authorize. I confirm that a photocopy or electronic copy of this authorization shall be valid as the original. I declare that the information provided in this form is accurate and any statements provided in any personal or telephone interview concerning this claim will be true and complete. I agree that all such statements form the basis for any benefit approved as the result of this claim.

### ClaimSecure

**For Extended Health Services (eg. Prescription drugs, physiotherapy, ambulance, eyeglassses/contact lenses, etc.)**

I certify that the above information is true and complete and that the above charges were for goods and services received by me, my spouse or my eligible dependents. I certify that I am authorized to disclose and receive information about my spouse and/or dependents for purposes of assessing and paying a benefit if any. I acknowledge that unless assigned to the service provider, any reimbursement of the above charges and explanation of such amounts paid will be provided to the benefit plan member. I authorize ClaimSecure, healthcare professionals, insurers, administrators of government or other benefit plans, and other service providers working with ClaimSecure to exchange necessary information regarding this claim to administer my health benefit plan.

PLEASE ATTACH ALL ORIGINAL INVOICES

**Important - Check one of the following boxes:**

| | | | | |
|---|---|---|---|---|
| ☐ | PAYMENT IS TO BE MADE TO THE STUDENT | INCLUDE PROOF OF PAYMENT | ☐ | PAYMENT IS TO BE MADE TO THE HOSPITAL/DOCTOR/CLINIC |

**PAYMENT METHOD:** ☐ CHEQUE ☐ ELECTRONIC FUNDS TRANSFER (FOR EFT PAYMENTS, COMPLETE FIELDS BELOW AND CHECK FOR ACCURACY)

*CANADIAN BANK ACCOUNTS ONLY

CLICK HERE TO VIEW EXAMPLE

| BANK NAME | ACCOUNT HOLDER NAME | PAYEE NAME (IF DIFFERENT FROM ACCOUNT HOLDER) |
|---|---|---|
| | | |

| ACCOUNT HOLDER ADDRESS |
|---|
| |

| PAYEE EMAIL | TRANSIT NUMBER | FUINANCIAL INSTITUTION NUMBER | ACCOUNT NUMBER |
|---|---|---|---|
| | | | |

| NAME (PLEASE PRINT) | STUDENT ID | DATE (DD-MM-YYYY) | X SIGNATURE OF PATIENT/GUARDIAN (**YOU MUST SIGN HERE**) |
|---|---|---|---|
| | | | |

### WHEN YOUR CLAIM IS RECEIVED...

Please note that all claims are subject to standard adjudication processing. You should expect a response within 30 days from from date claim is received by Morcare Insurance. Our response would be one of the following: (A) Payment or Notification of Payment to a Provider; (B) Request for more information if required; (C) Acceptance or Denial of the claim with reasons.

## SECTION 6. SUBMISSION

### Please send your claim to the following email: claims@morcare.ca

Secondary option via mail: Morcare Insurance, 2255 Sheppard Ave East, Suite 202, 2nd Floor, Atria 1, Toronto, ON M2J 4Y1

**PROTECTING THE PRIVACY OF YOUR PERSONAL INFORMATION**

Industrial Alliance Insurance and Financial Services Inc. (the "Company") recognizes and respects every individual's right to privacy. Personal information about you is kept in a confidential claim file at the offices of the Company or of an organization authorized by the insurer in a secure area. We limit access to information in your files to our staff or persons authorized by the Company who require this access to perform their duties, to persons to whom you have granted access, and to persons authorized by law. We use this information to investigate, assess and administer your claim and the terms of the insurance contract provisions. You may access the personal information contained in your file and correct any inaccurate information. Any personal health information will be provided to you through a medical practitioner of your choice. To view your personal information please send a request in writing to the attention of the Claims Department at Industrial Alliance Insurance and Financial Services Inc., 2165 Broadway W, PO Box 5900, Vancouver, BC, V6B 5H6, together with the name of the medical practitioner.