MSH INTERNATIONAL
SIACI SAINT HONORE GROUP

MEDICAL AND DENTAL CLAIM FORM

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- **Please ensure that all areas of this form are completed in full to avoid any delays in your reimbursements;**
- **All claims must be received by MSH INTERNATIONAL within 90 days following the date the expense was incurred.**
- **No claims will be paid, directly or indirectly, in contravention of any restrictions imposed for example by the United Nations, the Office of Foreign Assets Control (OFAC) from the U.S. Department of the Treasury or the European Union, in respect of countries subject to sanctions.**

GROUP NAME: INSURE2STUDY			
NAME ***(first and last):***	**DATE OF BIRTH** ***(mm/dd/yy):***	**POLICY NUMBER:**	
STREET ADDRESS:			
CITY:	**STATE/PROVINCE:**	**COUNTRY:**	**POSTAL/ZIP CODE:**
EMAIL:	**PHONE** ***(include country code):***	**CERTIFICATE NUMBER:**	

Is your treatment due to an accident? Is your Dependent's treatment due to an accident?	☐ Yes ☐ No ☐ Yes ☐ No ☐ n/a	If yes, may another person be responsible?	☐ Yes ☐ No
THE FOLLOWING FIELD IS MANDATORY:			
Do you have other insurance coverage? Are you currently making a claim with this insurer?	☐ Yes ☐ No ☐ Yes ☐ No	If yes, please provide name and address of insurer, contact AND policy number:	

DEPENDENTS *(complete for all Dependents being claimed for on this form)*

If your Dependent Child is considered Over Age, please indicate if they are full-time student or disabled. If a full-time student please submit confirmation of enrolment. Please refer to your benefit booklet or policy for Dependent eligibility requirements.

Patient Name	Relationship to Employee *(spouse, son, daughter, etc.)*	Date of birth *(mm/dd/yy)*	Full-time student	Physical or Mental Disability?
		| |	☐ Yes ☐ No	☐ Yes ☐ No
		| |	☐ Yes ☐ No	☐ Yes ☐ No
		| |	☐ Yes ☐ No	☐ Yes ☐ No
		| |	☐ Yes ☐ No	☐ Yes ☐ No

MEDICAL SERVICES *(please use a separate form for additional items if required)*

Completion of diagnosis/reason for treatment is mandatory. Failure to complete this section will result in delays of claims reimbursement.

Patient Name	Date of service *(mm/dd/yy)*	Service type/Name of drugs *(doctor visits, hospital, etc.)*	Diagnosis/Reason for treatment *(for each service received)*	Is this your primary consultation/treatment?	Amount Charged
	| |			☐ Yes ☐ No	
	| |			☐ Yes ☐ No	
	| |			☐ Yes ☐ No	
	| |			☐ Yes ☐ No	
	| |			☐ Yes ☐ No	
				TOTAL AMOUNT CLAIMED FOR MEDICAL SERVICES (INCLUDING CURRENCY):	

PHYSICIAN'S STATEMENT *(to be completed by physician)*

Attach original receipts. Physician statement is required if attached receipts do not include adequate information of the illness, injury and/or for treatment received. Attach additional note if necessary.

Doctor's Name (*print*) and Signature	**Date *(mm/dd/yy)***

DENTAL SERVICES *(to be completed by dentist)*

Date of service *(mm/dd/yy)*	Treatment	Procedure Code	Tooth Surfaces	Dentist's Fee	Laboratory Charges	Total Charges
| |						
| |						
| |						
| |						
				TOTAL AMOUNT CLAIMED FOR DENTAL SERVICES (INCLUDING CURRENCY):		

ASSIGNMENT OF BENEFITS

If you are authorizing reimbursement to another party, please complete this section. Failure to complete this section will result in reimbursement being made according to the current information available on file.

Name of party	**Signature of primary insured**
Date *(mm/dd/yy)*	

CLAIM PAYMENT INFORMATION

I understand it is my responsibility to advise MSH INTERNATIONAL of any changes in banking information.

Please indicate if you would prefer to receive your claim payments via:
☐ **Cheque.** Please confirm currency of claim reimbursements:_____ (***Note:*** *you will be notified if we are unable to process your currency of choice)*;
☐ **Wire Transfer.** For wire transfer payments, please attach a void cheque and provide the bank account details as required by the receiving bank.

BANK INFORMATION	
Beneficiary Bank Name	
Bank Indentification Number	
Address of Beneficiary Bank	
Currency of Bank account	
Swift Code	
BENEFICIARY INFORMATION	
Beneficiary Account Number	
Beneficiary Name	
Beneficiary Address	
ABA Code (accounts in the USA)	
Swift Code (all other accounts)	

Please note, your bank may charge you fees to receive a wire transfer. Any fees charged by the receiving bank are the responsibility of the beneficiary.

I hereby warrant the truth of all statements on this form and give MSH INTERNATIONAL permission to contact the medical attendants directly, if required. I agree to supply further information, medical or otherwise, required to complete the assessment of these claims. I also give MSH INTERNATIONAL permission to send communications pertaining to my claims and the administration of my group benefits plan to the email I supply on this claim form.

Signature	**Date *(mm/dd/yy)***

At MSH INTERNATIONAL, we recognize and respect the importance of privacy. When you submit a claim, the insurers establish a confidential file that is kept in the offices of the insurers or the offices of an organization authorized by the insurers. We limit access to information in your file to insurer staff and/or the insurers who require it to perform their duties, to persons to whom you have granted access, and to persons authorized by law. We use this information for the purpose of assessing your claim and administering the group benefits plan. Personal information is protected from unauthorized use and disclosure in accordance with the *Freedom of Information and Protection of Privacy Act*.