



JF ELITE INTERNATIONAL STUDENTS CLAIM FORM

INSTRUCTION: Please attach all original official itemized invoices and/or receipts with copy of assessments and/or test results.

POLICY NO: SRG9116092-1 Policy Holder: _____ CERTIFICATE#: JFE _____

SECTION A STUDENT INFORMATION – MUST BE COMPLETED BY INSURED

Last Name: _____ First Name: _____

Date of Birth: YYYY / MM / DD Male Female E-mail: _____

Address in Canada - # & Street: _____ Apt.# _____

City: _____ Province: _____ Postal Code: _____ Phone# _____

School attending: _____ Phone# _____

School address: _____

SECTION B INFORMATION ON PARAMEDICAL SERVICES, X-RAY OR LABORATORY EXPENSES

NATURE OF ILLNESS	SERVICE RENDERED	SERVICE DATE YYYY / MM / DD	AMOUNT CHARGED	REFERRED BY (DOCTOR'S NAME)
1)			\$	
2)			\$	
3)			\$	

TOTALS \$ _____

SECTION C HOSPITAL, MEDICAL OR PHYSICIAN SERVICES – MUST BE COMPLETED BY YOUR PHYSICIANS

Diagnosis and Procedures – Use exact wording of schedule of fees: _____

Symptoms or injury first appeared: YYYY / MM / DD First saw physician for this condition: YYYY / MM / DD

SERVICE CODE	NUMBER OF SERVICES	SERVICE DATE YYYY / MM / DD	AMOUNT CHARGED	DIAGNOSTIC CODE
			\$	
			\$	
			\$	

TOTALS \$ _____

I DECLARE THAT THE ABOVE IS A CORRECT STATEMENT OF SERVICES PERSONALLY RENDERED BY ME.

Signed this on the _____ day of _____ in 20 _____ at _____

Physician's name: _____ Clinic stamp: _____

Physician's signature: _____

MD or Certified Specialist

MAIL TO:

Johnson Fu Insurance Agency Inc.

128-6061 No. 3 Road, Richmond, BC, V6Y 2B2
Phone: 604-232-0896 Fax: 604-232-0897
www.jfuinsurance.com

SECTION D DENTAL EXPENSES – MUST INCLUDE YOUR DENTISTS STANDARD DENTAL CLAIM FORM.

Description of emergency or accident: _____

Injuries sustained: _____

Date of emergency or accident: YYYY / MM / DD Date of initial dental attention: YYYY / MM / DD

PROCEDURE CODE	SERVICE DESCRIPTION	TOOTH NUMBER	AMOUNT CHARGED	SERVICE DATE YYYY / MM / DD
			\$	
			\$	
			\$	

TOTALS \$ _____

SECTION E AUTHORIZATION AND RELEASE

PERSONAL INFORMATION NOTICE: I understand that the information provided by me on this claim form and otherwise in respect of my claim, is required by AIG Insurance Company of Canada, its reinsurance and authorized administrators (the "insurer") to assess my entitlement to benefits, including but not limited to determining if coverage is in effect, investigating the applicability of exclusions and co-ordinating coverage with other insurers. For these purposes, the insurer will also consult its existing insurance files about me, collect additional information about and from me, and where required, collect information from and exchange information with, third parties.

CERTIFICATION: The statements I provide in completing this claim form and otherwise in respect of my claims are true and complete to the best of my knowledge and belief. In the event of a false or misleading statement in the making of this claim, coverage can be cancelled, payment of benefits denied and past claims payments recovered. I agree to refund to the Insurer, the amount of any payments made in the event that amounts should not have been paid in respect of my claim.

AUTHORIZATION: I authorize, for a period of not less than twelve and not more than twenty-four months from the date hereof, any physician, practitioner, health care provider, hospital, health care institution, medical organization, clinic and any other medical or medically related facility, any insurance company or reinsurance company, workers compensation board or similar plan or organization, benefit plan administrator, federal, territorial or provincial government department, or any other corporation or organization, institution or association (including obtaining information from the group policyholder or my employer) to release and exchange with AIG Insurance Company of Canada, or representatives thereof, all personal health information and benefit payment information about me or any other information or records about me in its possession that is requested while administering my claim.

I agree that a reproduction of this authorization shall be a valid as the Original.

Insured's signature: _____ Date: YYYY / MM / DD

CHEQUE SHOULD BE PAYABLE TO:

Insured to the above address Parent/Guardian Provider School Other

If payable to parent/guardian, provider, school or other person, please indicate below:

Payable to: _____ Relation to Insured: _____

Address in Canada - # & Street: _____ Apt.# _____

City: _____ Province: _____ Postal Code: _____ Phone# _____

Insured's signature: _____ Date: YYYY / MM / DD

if minor (under 12 years of age), signature of parent or legal guardian

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