AIG Insurance Company of Canada
145 Wellington Street West
Toronto (Ontario) M5J 1H8

JF INTERNATIONAL STUDENTS USA CLAIM FORM

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

POLICY NO: SRG9125996 Policy Holder: _____ CERTIFICATE#: JFS_____

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 USA - # & Street: Apt.#

City: State: Zip 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:

Physician's signature:

MD ☐ or Certified Specialist ☐

Clinic stamp:

MAIL TO:

JF Insurance Agency Group Inc.
15 Wertheim Court, Suite 501, Richmond Hill, ON, L4B 3H7
Phone: 1-877-832-5541 I Fax 1-888-988-3268
www.ifuinsurance.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 USA - # & Street: Apt.#

City: State: ZIP Code: Phone#

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

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

MAIL TO:

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