

CLAIM FOR HEALTH BENEFITS

Enclose original receipts - carbon or photocopies are not acceptable. It is suggested that you accumulate at least \$30 in total expenses before submitting a claim.



STUDENT STATEMENT

RWAM Group # 490010	Name of Student	Student I.D.#
Indicate address where you would like claim cheque or correspondence mailed:		Telephone #
		Email Address
Permanent Home Province of Residence (if different from student address)		

TOTAL EACH TYPE OF EXPENSE - FOR EACH CLAIMANT ON A SEPARATE LINE

First Name	Relationship	Date of Birth Day Mo. Yr.			Type of Expense ie. Drugs, Vision, Practitioner, etc.	Total Amount Charged
TOTAL						
If this claim is for a dependent, is the dependent employed? Yes <input type="checkbox"/> No <input type="checkbox"/>				Does the claimant have any other group health coverage? Yes <input type="checkbox"/> No <input type="checkbox"/>		
If "Yes" Full-time <input type="checkbox"/> Part-time <input type="checkbox"/>				If "Yes", indicate the name of the insurer:		

Authorization:

I understand the information I provide on this form will be used to determine my eligibility for group insurance benefits claimed under this policy/plan. I certify that the charges listed above and for which the bills are attached, were incurred by myself or one of my eligible dependants. The charges were incurred upon the recommendation and approval of the attending physician (where required by this policy/plan) and were required medical treatment. I declare that the statements made on this form are complete and true. I hereby authorize the release of any information in respect to this claim, requested by RWAM Insurance Administrators Inc. ("RWAM"), to RWAM and to the insurer. I also authorize my plan administrator, Society of Graduate Students to exchange information, which is necessary and related to this claim, on my behalf with RWAM and the insurer. A photocopy or facsimile transmission of this authorization shall be considered as valid as the original.

Date _____ Signature of Student _____

This form must be completed in full. If not, the form will be returned to you which will delay the processing of the claim. If you have any questions regarding your student health plan, please inquire at the SOGS Office, Room 260, UCC, The University of Western Ontario, London, ON N6A 3K7 Tel. 519-661-3394.

Once completed, please forward to: **RWAM INSURANCE ADMINISTRATORS INC., 49 Industrial Drive, Elmira, ON N3B 3B1**



RC031_University SOGS_07.07

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