DSU International Students Insurance Plan
Authorization and Assignment of Payment Form

First Name: _____ Last Name: _____

Student ID: _____ Date of Birth: _____

Phone Number: _____ E-mail: _____

Canadian Mailing Address: _____

City: _____ Postal Code: _____

CERTIFICATION AND AUTHORIZATION FOR RELEASE OF INFORMATION

By signing below, you authorize the Dalhousie Health & Wellness on your behalf, to submit claims and obtain payments for all services performed for you, your spouse and your dependents during the Coverage Period.

You agree to take all reasonable steps to ensure all information submitted to Medavie Blue Cross by the Providers is complete and accurate and will notify Medavie Blue Cross if you become aware of any discrepancies with the services billed on your behalf.

You understand that the information provided by you to Medavie Blue Cross about yourself, your spouse and your dependents, [as well as currently held or collected in the future by] your Medavie Blue Cross [plan may be collected, used, or disclosed] by Medavie Blue Cross and its agents/administrators [to administer and manage the terms of my plan or the group plan of which I am an eligible member or dependent], for claim adjudication and any other services necessary in the administration of [my] benefits which may include the exchange of information with [any other third party stated herein].

You confirm that you are authorized by your spouse and/or dependents to disclose and receive information about them that is used for the aforementioned purposes. You confirm that your spouse and/or dependents understand that this information may be seen by you, the member.

The cost (if any) of obtaining information required for the payment of the claim is at the expense of the patient or plan member. All claims must be submitted within 12 months from the date of service unless otherwise stated in your benefit plan documentation.

You confirm that you, your spouse and/or dependents authorize Medavie Blue Cross and its agents/ administrators access to your medical records for the purpose of auditing the claimed expenses and or any other services relating to the adjudication of your claims.

Medavie Blue Cross, as the administrator and the Insurer, shall have full rights of subrogation, including the right to proceed in the Insured Person's name against third parties who may be responsible for a claim arising or for providing indemnity or benefits similar to the benefits under this Certificate. The Insured Person shall give Medavie Blue Cross all such assistance as is reasonably required to secure the Insurer's rights and remedies, including the execution of all documents necessary to enable the Insurer to bring suit in the name of the Insured Person, as applicable.

Subrogation from a Third Party: In the event of a payment under this insurance, Medavie Blue Cross, as the administrator and the Insurer, has the right to proceed in the name of any Insured Person against third parties who may be responsible for giving rise to a claim.

I agree that a photocopy or facsimile of this authorization shall be valid as the original and that this authorization shall be considered valid for the duration of this claim, but not to exceed four years from the date it is signed. I understand information about me may be reviewed in the event that this plan is audited.

I have read, understand and consent to receive communications from the DSU Health Plan Office, Student VIP International and Medavie Blue Cross by mail at both my Canadian and Home Country address for the sole purpose of processing any current or outstanding claim(s). I understand that I will only be contacted at my Home Country Address as a means of last resort.

I authorize the Dalhousie University Students' Union ("DSU") and Dalhousie University, Medavie Blue Cross (Administrator and Insurer), and C&C Insurance Consultants (benefit consultant) to collect and exchange personal information about me and/or my dependents to process claims and administer my plan. I understand any personal information obtained by these entities will be kept confidential and secure, and where necessary, will be exchanged with any licensed physician, health care practitioner, medical facility or provider of healthcare/dental service, any provincial health insurance plan, insurance company or reinsurer, auditing or independent investigative organization, and financial institution, applicable to the day-to-day scope of this benefit plan.

I understand that until my enrolment is verified by the University and I meet all eligibility requirements for this policy, my coverage may not be active.

I understand that I may revoke my consent at any time, however, in some instances doing so may prevent Medavie Blue Cross from providing me with the requested coverage or benefits. I understand why my personal information is needed and I am aware of the risks and benefits of consenting or refusing to consent to its disclosure.

hereby authorize the release of any information or records requested in respect to [my claims] to the insurer or its agents and certify that the information given is true, correct and complete to the best of my knowledge

CERTIFICATION: By signing below, you confirm that the services listed within this submission were performed and all information provided with this claim submission is complete and accurate. The undersigned hereby certified that the information provided by him or her is complete and accurate to the best of each his or her knowledge and belief. In the event of a false or misleading statements and/or claims, coverage can be void. The undersigned certifies he or she have the authority to provide all required authorization and information.

CASL AUTHORIZATION: I have read, understand and consent to receive communications from Medavie Blue Cross and Student VIP International by e-mail. If you wish to no longer receive communication by email, please call 1-833-867-3468.

_____ **Initial** **I understand that if I elect to opt out of coverage, I will not receive a refund of any of the premium paid if a claim has been paid under my policy.**

Insured Signature: _____ Date: _____

Medavie Blue Cross and its agents/ administrators are committed to protecting the privacy, confidentiality and security of the personal information collected, used and retained. Travel insurance does not cover everything. Please refer to your benefits booklet for full terms and conditions, including the including the definitions for the defined terms used in this form.