Claims Administration
OLD REPUBLIC INSURANCE COMPANY OF CANADA
Box 557, 100 King Street West, Hamilton, Ontario L8N 3K9
Toll Free: 888.831.2222
Fax: 866.551.1704
Email: travelanceclaims@orican.com

STUDENT ACCIDENT INSURANCE CLAIM FORM

Note: If the insured is a minor, this form should be completed and signed by a parent or guardian.

Part I	
Name of School Board	insuremykids® Policy No.
Name of School	Grade
Name of Insured *(Last, First)*	Birthdate *(MM / DD / YY)*
Address *(Street, City, Province, Postal Code)*	
Name of Parent(s)/Guardian(s)	Email Address
Primary Phone No.	Secondary Phone No.

Part II	
Did accident occur at school or during school activity? ❑ Yes ❑ No	
Date of Accident *(MM / DD / YY)*	Time of Accident *(Hour)*
Location of Accident	
Nature of Injury	
If taken to hospital, name and address of hospital	
Date and Time of Admittance	Date and Time of Discharge
Name of Attending Physician or Dentist	
Address	Date of first treatment *(MM / DD / YY)*

Part III	
Describe fully how the accident occurred	
Name of Witness 1	Address of Witness 1
Name of Witness 2	Address of Witness 2

Part IV	
What benefit(s) are you claiming?	Amount Claimed $
Is there coverage under any other insurance or benefit plan (e.g. Group Insurance through your Employer)? ❑ Yes ❑ No If yes, please complete the following:	
Name of Insurance Company / Institution A	Policy No.
Address of Company A	Certificate No.
Name of Insurance Company / Institution B	Policy No.
Address of Company B	Certificate No.

I HEREBY AUTHORIZE any physician, hospital, clinic or other medically related facility, any insurance company, government office or institution or any person or persons, legal or real, to furnish **OLD REPUBLIC INSURANCE COMPANY OF CANADA** with any and all details of my or my child's insurance and medical history. A copy of this authorization shall be valid as the original.

Date *(MM / DD / YY)* _____ Signature _____

CLAIM PROCEDURES

(A) Complete first page of this form FULLY. Please do not submit claims for expenses covered under a Government or other Health Plan.
(B) For claims requiring a report from a Physician, please have a Physician complete the Attending Physician's Statement on the second page of this form.
(C) For claims requiring a report from a Dentist, please have a Dentist complete the Dental Claim form on the third page of this form.
(D) **The company must be notified within 60 days of the date of accident and proof of claim, including a report from the attending Doctor or Dentist, must be submitted within 90 days of the date of the accident.**
(E) This Form and all insured accounts which you are required to pay should be forwarded without delay to the address above.

Please complete this claim form and return it to your patient. *Any charge for completing this form is the patient's responsibility.*

ATTENDING PHYSICIAN'S STATEMENT - TO BE COMPLETED BY THE PHYSICIAN

Patient's Name *(Last, First)*	Age

Address *(Street, City)*	Address *(Province, Postal Code)*

Diagnosis: Please indicate the Name(s) of the bone(s) fractured dislocated:

If hospitalized, please give name of hospital

Date Admitted *(MM / DD / YY)*	Date Discharged *(MM / DD / YY)*

If referred **to you**, please give name of referring Physician:

If referred **by you** to another Physician, Physiotherapist, Chiropractor or other practitioner please give name and type of Practitioner:

OPERATIONS (or other procedures performed)

1		Date *(MM / DD / YY)*
2		Date *(MM / DD / YY)*
3		Date *(MM / DD / YY)*

Date of first consultation above *(MM / DD / YY)*

Date of first symptom(s) *(MM / DD / YY)*

Date of accident *(MM / DD / YY)*

Has the patient ever had a similar condition? ❑ Yes ❑ No
If yes, please state when and describe:

Is there any other disease or infirmity affecting the present condition? ❑ Yes ❑ No

If yes, please describe

Name *(Please Print)*	Signature

Date *(MM / DD / YY)*	Certified Specialty

Address *(Street, City, Province, Postal Code)*

Phone No.	Fax No.

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STUDENT ACCIDENT INSURANCE DENTAL CLAIM FORM

Part 1 Dentist

Dentist Information

Name _____

Address _____

City _____ Province _____ Postal Code _____

Telephone

Patient Information

Name _____

Address _____

City _____ Province _____ Postal Code _____

Telephone

Date of Service Month MMM	Day DD	Year YYYY	Int. Tooth Code	Procedure Code	Tooth Surfaces	Laboratory Charge	Dentist's Fee	Total Charge

For plan administrator use only

This is an accurate statement of services performed and fees charged. E & OC

TOTAL SUBMITTED FEE →

_____
Dentist's Signature

Date: Month MMM | Day DD | Year YYYY

For dentist's use only. For additional information re: diagnosis, procedures, or complications, and special considerations.

_____

_____

I understand that the fees listed in this claim may not be covered by or may exceed my policy benefits. I understand that I am financially responsible to my dentist for the entire cost of the treatment. I authorize release of the information contained in this claim form to my insuring company or its agents.

_____
Signature of patient (parent/guardian)

I hereby assign benefits payable from this claim to the above named dentist and authorize payment directly to the dentist.

_____
Signature of patient (parent/guardian)

Part 2 Dentist Supplementary Report (must be completed in full)

1. Description of damage _____

_____

_____

_____

2. Is further treatment indicated? No ☐ Yes ☐ If "yes" please indicate:

Int. Tooth Code		Treatment indicated – Use procedure code if possible	Est. Date - Treatment Month MMM	Day DD	Year YYYY

3. Describe further potential problems and indicated time frame _____

_____

_____

Dated _____ / _____ / _____ _____
MONTH DAY YEAR (4 DIGITS) Dentist's Signature

All information recorded on this form is confidential