PACIFIC BLUE CROSS®

DO NOT WRITE IN THIS SPACE

CLAIM FOR TUITION EXPENSES STUDENT'S STATEMENT

Mail: PO Box 7000, Vancouver, BC V6B 4E1 | Drop it off: 4250 Canada Way, Burnaby, BC

Please read the following carefully before completing this form.

- Attach to this form **original receipts** for books and other mandatory expenses and fees that are non-refundable and non-negotiable, and that you cannot use after withdrawal from college or university. Be sure to keep copies as originals are not returned to you.
- Forward this form along with the *Claim for Tuition Expenses — Physician's Statement* form, completed and signed by your doctor, to Pacific Blue Cross.
- Revenue Canada will accept copies of receipts and benefits statements as proof of payment for your income tax return. Other insurance carriers will also accept copies for coordination of benefits.
- **For information, visit www.studentcare.ca or call 1 877 789-8714**.

PART 1 — STUDENT INFORMATION

Plan sponsor/name of educational institution		Policy number	ID number
First name	Last name	Sex ☐ M ☐ F	Birthdate (mm-dd-yyyy)
Street address	PO box (if applicable)	City	Province / Postal code
Phone number (10 digits)	Student ID number (printed on your student ID card)	Email address	

PART 2 — PHYSICIAN(S) INFORMATION

Date you became unable to attend school (mm-dd-yyyy)	Date you first saw a physician after you stopped attending school (mm-dd-yyyy)

Name and phone number of physician(s) involved in your medical care:

Name 1.	Speciality	License number	Phone number (10 digits)
Street address	City	Province	Postal code
Date of latest visit (mm-dd-yyyy)	Frequency of visits: ☐ Weekly ☐ Monthly ☐ Other: _____		Date of next visit (mm-dd-yyyy)
Name 2.	Speciality	License number	Phone number (10 digits)
Street address	City	Province	Postal code
Date of latest visit (mm-dd-yyyy)	Frequency of visits: ☐ Weekly ☐ Monthly ☐ Other: _____		Date of next visit (mm-dd-yyyy)

PART 3 — NATURE OF ILLNESS/INJURY

Please describe any limitations and restrictions you have as a result of your medical condition(s):

Describe in detail the way in which your symptoms prevent you from attending school:

PART 4 — RETURN TO SCHOOL PLANS

1. Have you returned to college or university part-time? ☐ Yes ☐ No If yes, date (mm-dd-yyyy): _____
2. Have you returned full-time? ☐ Yes ☐ No If yes, date (mm-dd-yyyy): _____
3. If you have not returned, when do you think you will be able to return?
   - ☐ I do not anticipate returning on either a part-time or full-time basis.
   - ☐ I anticipate returning part-time on or around this date (mm-dd-yyyy): _____
   - ☐ I anticipate returning full-time on or around this date (mm-dd-yyyy): _____

PART 5 — AUTHORIZATION

I certify that the information provided on this form is true and complete to the best of my knowledge and belief.

I understand and consent that the personal information on this form as well as other personal information currently held or collected by Pacific Blue Cross may be collected, used or disclosed to administer the terms of my plan and to assess and process my claim. Some of my personal information may be collected from and/or released to a third party for the purposes listed above. This may include a licensed physician, other medical professionals and medical institutions, investigation agencies, insurers, reinsurers, adjusters, and authorized agents of Pacific Blue Cross.

I authorize Pacific Blue Cross and my plan sponsor and their authorized agents to collect, use and disclose among them my personal information for the purposes described above as well as for planning and managing my rehabilitation and return to school, except for details related to diagnosis, treatment or medication relevant to my claim.

When there is suspicion of fraud and/or plan abuse of my claim, I acknowledge and agree that Pacific Blue Cross may collect, use and disclose information about me pertaining to my claim to any relevant third party, which may include my plan sponsor, regulatory bodies, government organizations, and other insurers, to investigate and prevent fraud and/or plan abuse.

I understand my personal information will be kept confidential and secure. I understand I may revoke my consent at any time by contacting Pacific Blue Cross in writing; however, if I withhold or revoke my consent, my claim may be denied or rescinded. 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.

If there is an overpayment, I authorize the recovery of the full amount of the overpayment from any amount payable to me under my benefit plan(s).

I agree that a photocopy of this authorization or electronic version is as valid as the original. I understand I am responsible for any fees related to the completion of forms by my physician.

IMPORTANT: Please also complete the Claims for Tuition Expenses Physician's Statement and forward both forms to Pacific Blue Cross.

Student's name (please print)	ID number
Student's signature **X**	Date (mm-dd-yyyy)

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MAIL YOUR CLAIM
Pacific Blue Cross
PO Box 7000, Vancouver, BC V6B 4E1

DROP IT OFF
4250 Canada Way
Burnaby, BC V5G 4W6