

mycanadaplan is becoming

# ALUMO International Student Health Care Claim Form

All claims must be submitted to Morcare at the address below within 6 months from the date on which the expenses are incurred or November 30th, 2026; whichever is earlier. Claimants must provide a valid Canadian address for reimbursement. Claimant reimbursement cheques will not be issued to a non-Canadian address.



Download the Morcare app to submit claims online or send your claim to the following email: [info@mycanadaplan.ca](mailto:info@mycanadaplan.ca)

Secondary option via mail: Gallivan Student Health & Wellness - A People Corporation Company, 231 Shearson Cres. Ste.310, Cambridge, ON N1T 1J5



## SECTION 1A. STUDENT INFORMATION

PLEASE PRINT CLEARLY

Please provide the following information:

|                                           |             |
|-------------------------------------------|-------------|
| TELEPHONE NUMBER                          |             |
| EMAIL ADDRESS                             |             |
| CANADIAN ADDRESS (STREET NUMBER AND NAME) |             |
| APARTMENT / UNIT NUMBER                   | CITY        |
| PROVINCE                                  | POSTAL CODE |

## SECTION 1B. DEPENDENT INFORMATION (SPOUSE OR CHILD OF STUDENT)

PLEASE PRINT CLEARLY

**Complete this section only if you are submitting a claim for a dependent.**

List the names of all persons for whom you are claiming expenses. Add up all the receipts and insert the total amount claimed. Ensure each receipt clearly indicates the type of expense being claimed. Attach ORIGINAL receipts indicating that you have paid the provider in full (photocopied bills/receipts are not acceptable).

| LAST NAME | FIRST NAME | Gender | Date of birth<br>(dd-mm-yyy) | Relationship to you | IF OVER 18 YEARS OF AGE                                     |                                                             | Amount claimed |
|-----------|------------|--------|------------------------------|---------------------|-------------------------------------------------------------|-------------------------------------------------------------|----------------|
|           |            |        |                              |                     | Full-time student                                           | Handicapped child                                           |                |
|           |            |        |                              |                     | <input type="checkbox"/> YES<br><input type="checkbox"/> NO | <input type="checkbox"/> YES<br><input type="checkbox"/> NO | \$             |
|           |            |        |                              |                     | <input type="checkbox"/> YES<br><input type="checkbox"/> NO | <input type="checkbox"/> YES<br><input type="checkbox"/> NO | \$             |

## SECTION 2. INFORMATION ABOUT YOUR CLAIM

PLEASE PRINT CLEARLY

**Please describe the reason for your claim and your symptoms.**

For example: stomach ache, migraine, broken bone, fever, eye infection, eye glasses/contacts, massage therapy, prescription drugs, etc.

|                                                  |                         |
|--------------------------------------------------|-------------------------|
| Date first diagnosed with symptom(s) (dd-mm-yy): | TOTAL AMOUNT OF CHARGES |
|                                                  | \$                      |

Is your claim related to pregnancy? ☐ No ☐ Yes If yes, please provide due date (dd-mm-yy):

|                                                                                                                                            |                               |
|--------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|
| Is your claim the result of an accident? <input type="checkbox"/> No <input type="checkbox"/> Yes<br>If yes, please explain what happened: | DATE OF ACCIDENT (DD-MM-YYYY) |
|--------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|

Is your claim related to any of the following?

☐ Co-op Work Placement for School (Attach co-op placement confirmation) ☐ School Program (ECE, Nursing etc.) (Attach notice of medical requirements)

Please carefully read this entire page if you are claiming medical expenses under your Provincial Alternative Coverage.

Examples Include:

- Hospital visits/hospitalization
- Walk in clinic
- Ultrasound/x-rays
- Emergency room visits
- Physician visit
- Blood tests

### SECTION 3. PARAMEDICAL EXPENSES

PLEASE PRINT CLEARLY

This section to be completed if claiming for paramedical services, x-rays, or laboratory fees.

| Date service rendered (dd-mm-yyy) | Nature of illness or injury | Claim description | Amount charged | Name of Doctor prescribing service | Date first consulted for condition (dd-mm-yyy) |
|-----------------------------------|-----------------------------|-------------------|----------------|------------------------------------|------------------------------------------------|
|                                   |                             |                   |                |                                    |                                                |
|                                   |                             |                   |                |                                    |                                                |
|                                   |                             |                   |                |                                    |                                                |
|                                   |                             |                   |                |                                    |                                                |

### SECTION 4. PHYSICIAN'S ACCOUNT RECORD (FOR THE COMPLETION BY THE PHYSICIAN)

PLEASE PRINT CLEARLY

Your physician must complete this section if claiming for hospital, medical expenses or physician services

|                                                               |  |                    |      |                  |             |
|---------------------------------------------------------------|--|--------------------|------|------------------|-------------|
| PHYSICIAN'S NAME                                              |  | PROVIDER ID NUMBER |      | TELEPHONE NUMBER |             |
| ADDRESS OF PROVIDER (STREET NUMBER AND NAME)                  |  | SUITE NUMBER       | CITY | PROVINCE         | POSTAL CODE |
| DATE PATIENT FIRST CONSULTED YOU WITH SYMPTOM(S) (DD-MM-YYYY) |  |                    |      |                  |             |

| Service date (dd-mm-yyyy) | Description of service | OHIP Procedure code (plus time units, if applicable) | Charge | Diagnostic code |
|---------------------------|------------------------|------------------------------------------------------|--------|-----------------|
|                           |                        |                                                      |        |                 |
|                           |                        |                                                      |        |                 |
|                           |                        |                                                      |        |                 |
|                           |                        |                                                      |        |                 |

DIAGNOSIS (DESCRIBE COMPLICATIONS, IF ANY) / PROCEDURES (USE EXACT WORDING OF SCHEDULE OF FEES)

I declare that the above is a correct statement of the services rendered by me.

X  
\_\_\_\_\_  
PHYSICIAN'S SIGNATURE (OR STAMP)

\_\_\_\_\_  
DATE (DD-MM-YYYY)

**Industrial Alliance Insurance and Financial Services Inc.****Medical Services under OHIP Alternative (eg. Hospital, Physician services, x-rays, blood tests, etc.)**

On behalf of myself, and/or spouse, and/or any minor insured, I RELEASE the information contained in this Claim Form to Industrial Alliance Insurance and Financial Services Inc. (the "Company") and ACKNOWLEDGE that this information will be used to assess, process and administer this claim and policy coverage.

I hereby authorize the Company, for the purposes of investigation, evaluation and administration of my claim:

- a) to gather only the information necessary for the above specified purposes from any person or organization that has personal information relating to me, including other insurers, reinsurers, and financial institutions; physicians, medical institutions and healthcare providers; employers or administrators of group benefits; agents or brokers; investigating and credit reporting agencies, and all persons or organizations likely to have personal information relevant to my claim.
- b) to disclose and exchange only the necessary personal information the Company has relating to me to the above persons and organizations.

I understand that the personal information obtained by the use of this authorization will be used by the Company in the investigation, administration and evaluation of a claim for benefits. Any information obtained will not be released by the Company, except to persons or organizations performing business or legal services in connection with my claim, or as may be otherwise lawfully required or as I may further authorize. I confirm that a photocopy or electronic copy of this authorization shall be valid as the original. I declare that the information provided in this form is accurate and any statements provided in any personal or telephone interview concerning this claim will be true and complete. I agree that all such statements form the basis for any benefit approved as the result of this claim.

PLEASE ATTACH ALL ORIGINAL INVOICES

**Important - Check one of the following boxes:**

|                          |                                      |                          |                          |                          |                                                     |
|--------------------------|--------------------------------------|--------------------------|--------------------------|--------------------------|-----------------------------------------------------|
| <input type="checkbox"/> | PAYMENT IS TO BE MADE TO THE STUDENT | <input type="checkbox"/> | INCLUDE PROOF OF PAYMENT | <input type="checkbox"/> | PAYMENT IS TO BE MADE TO THE HOSPITAL/DOCTOR/CLINIC |
|--------------------------|--------------------------------------|--------------------------|--------------------------|--------------------------|-----------------------------------------------------|

PAYMENT METHOD: ☐ CHEQUE ☐ ELECTRONIC FUNDS TRANSFER (FOR EFT PAYMENTS, COMPLETE FIELDS BELOW AND CHECK FOR ACCURACY)

\*CANADIAN BANK ACCOUNTS ONLY

CLICK HERE TO VIEW EXAMPLE

|                        |                     |                                               |                |
|------------------------|---------------------|-----------------------------------------------|----------------|
| BANK NAME              | ACCOUNT HOLDER NAME | PAYEE NAME (IF DIFFERENT FROM ACCOUNT HOLDER) |                |
| ACCOUNT HOLDER ADDRESS |                     |                                               |                |
| PAYEE EMAIL            | TRANSIT NUMBER      | FINANCIAL INSTITUTION NUMBER                  | ACCOUNT NUMBER |

X

NAME (PLEASE PRINT)

STUDENT ID

DATE (DD-MM-YYYY)

SIGNATURE OF PATIENT/GUARDIAN (YOU MUST SIGN HERE)

**When your claim is received...**

Please note that all claims are subject to standard adjudication processing. You should expect a response within 30 days from from date claim is received by Morcare Insurance. Our response would be one of the following: (A) Payment or Notification of Payment to a Provider; (B) Request for more information if required; (C) Acceptance or Denial of the claim with reasons.

**SECTION 6. SUBMISSION**

Please send your claim to the following email: [info@mycanadaplan.ca](mailto:info@mycanadaplan.ca)

Secondary option via mail: Gallivan Student Health & Wellness - A People Corporation Company, 231 Shearson Cres. Ste.310, Cambridge, ON N1T 1J5

**PROTECTING THE PRIVACY OF YOUR PERSONAL INFORMATION**

Industrial Alliance Insurance and Financial Services Inc. (the "Company") recognizes and respects every individual's right to privacy. Personal information about you is kept in a confidential claim file at the offices of the Company or of an organization authorized by the insurer in a secure area. We limit access to information in your files to our staff or persons authorized by the Company who require this access to perform their duties, to persons to whom you have granted access, and to persons authorized by law. We use this information to investigate, assess and administer your claim and the terms of the insurance contract provisions. You may access the personal information contained in your file and correct any inaccurate information. Any personal health information will be provided to you through a medical practitioner of your choice. To view your personal information please send a request in writing to the attention of the Claims Department at Industrial Alliance Insurance and Financial Services Inc., 2165 Broadway W, PO Box 5900, Vancouver, BC, V6B 5H6, together with the name of the medical practitioner.