

CLAIM FOR ACCIDENT BENEFITS



Enclose original receipts - carbon or photocopies are not acceptable.

Brock University Students' Union

STUDENT STATEMENT

RWAM Group # 490007	Name of Student	Student I.D.#
Student Address	Telephone #	
	Email Address	
	Permanent Home Province of Residence (if different from student address)	

ACCIDENT DETAILS

Date of Accident	Date of Medical Attention
<p>If you sustained dental injury as a result of your accident please attach a standard dental claim form fully completed and signed by your dentist. This form should include the dental treatment received, as well as x-rays of teeth prior to the accident. Please attach a pre-treatment form, completed by your dentist, if future treatment has been determined.</p>	
Full Details of Accident	
What Injuries Were Sustained	
Are there any claims for this accident under workers' compensation, auto insurance, or under any legal action? If so, please provide details:	

TREATING PHYSICIAN

Treating Physician's Name	Address
Phone and Fax #	
<p>Please include the Physician's referral for the services being claimed.</p>	

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 with respect to this claim, requested by RWAM Insurance Administrators Inc. ("RWAM"), to RWAM and to the insurer. I also authorize my plan administrator, Brock University Students' Union 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 on-site at the:

BUSU Health and Dental Plan Office
Room #314 Student Alumni Centre, Brock University, 500 Glenridge Ave.
St. Catharines, ON L2S 3A1 Tel. (905) 688-5550 Ext. 4194



STUDENTWISE Health & Dental Coverage For Students
 Arranged by Campbell & Company Insurance Consultants Ltd.



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