Mail To: TheCampusTrust
1st. Floor, Beothuck Building, 20 Crosbie Place
St. John's, Newfoundland A1B 3Y8

STATEMENT OF COVERED EXPENSES
FOR HEALTH CARE BENEFITS

PLEASE TYPE OR PRINT. YOUR CLAIM CANNOT BE PROCESSED UNLESS ALL QUESTIONS HAVE BEEN ANSWERED IN FULL. USE MORE THAN ONE FORM IF NECESSARY.

School location (City and Prov.)	School Name	Group No.	Account
	Holland College Student Union	**30W33**	**L**

Student's Name	Student I.D. Number	Date of Birth Mo. Day Yr.

Student's Address

No. and Street | City | Prov. | Postal Code

Do you have another plan that provides Health or Dental benefits for you or your dependents? ☐ **No** ☐ **Yes**

☐ **Health Only** ☐ **Dental Only** ☐ **Both**

If Yes, is the other coverage provided through: ☐ **The Trust** ☐ **Another Insurer Indicate Policy Number** ________________

If claim is for a dependent child, please indicate spouse's Date of Birth _____________________________

If claim is for child, indicate ☐ Full-time Student Date Enrolled ____________________ Date Completed ___________________ ☐ Handicapped

Is treatment a result of an occupational injury, or otherwise related to employment? ☐ No ☐ Yes

	FIRST NAME	SEX	DATE OF BIRTH M	D	Y	DATE EXPENSE INCURRED	NAME AND ADDRESS OF SUPPLIER OR PHARMACY	DRUGS: NAME OF D.I.N. OTHER: TYPE OF EXPENSE	AMOUNT CHARGED
STUDENT									
SPOUSE									
UNMARRIED CHILDREN									
								TOTAL CHARGES	

I certify that the charges for the medical supplies which are listed above and for which the bills are attached were incurred by myself on account of myself or of one of my eligible family members upon the recommendation and approval of the attending physician (if required under the terms of the Plan Text) and required in connection with the treatment of accidental bodily injury or sickness of myself or one of my family members.

AUTHORIZATION: On behalf of myself and my eligible dependents, I authorize my Students' Association and my group benefit provider, The Campus Trust and any of its affiliates or reinsurers to exchange the personal information contained on this form or any other benefit related personal information contained in their files now or in the future respecting me or any of my eligible dependents. I give my consent on the understanding that the information will be used solely for purposes of administration and management of my group benefit plan. This consent shall continue so long as I and my dependents are covered by, or are claiming benefits under the present group contract, or any modification, renewal or reinstatement thereof.

Date ____________ Signature of Student ____________ Telephone Number ____________

Date ____________ Signature of Spouse if claim is to be coordinated with another Benefit Plan ____________