Mail to: The Campus Trust
1st Floor, Beothuck Building, 20 Crosbie Place
St. John's, Newfoundland, A1B 3Y8
1-800-563-1930 Fax: 1-709-754-6733

MOUNT ALLISON STUDENTS' UNION

STATEMENT OF EXPENSES FOR HEALTH CARE BENEFITS

TO BE CONSIDERED AN ELIGIBLE EXPENSE, CLAIMS MUST BE RECEIVED WITHIN 6 MONTHS FROM THE DATE EXPENSE WAS INCURRED OR THE DATE YOUR PLAN TERMINATED USING THE DATE OF SERVICE OR THE DATE SUPPLIES WERE PURCHASED. YOUR CLAIM FORM MUST BE COMPLETED IN FULL.

Name of University or College Student Organization	Policy Number	MASU I.D. Number
Mount Allison Students' Union	**0940P001**	

Student Name	Date of Birth (D / M / Y)	Email Address

Local Mailing Address No. and Street	City	Province	Postal Code

Coordination Of Benefits

Do you have another plan that provides Benefits for you or dependants? Yes □ No □

If yes, indicate:

- Name of the Insurance Provider — Policy Number
- Type of Coverage — Health Only □ Dental Only □ Both □
- Policyholder's Name (if applicable): — Date of Birth:

Patient Information				Drug Expenses		Other Expenses	
Patient Name	Date of Birth D	M	Y	DIN or Drug Name	Total Charge	Type Of Expense	Total Charge
				Total:		Total:	

PLEASE ATTACH RECEIPTS AND DOCTOR REFERRALS, IF APPLICABLE. PHOTOCOPIES ARE ACCEPTED.

In signing this Statement of Expenses, I certify that the charges for the medical supplies which are listed above and for which the bills are attached were incurred by myself or one of my eligible dependants upon recommendation and approval of the attending physician (if required under the terms of the Plan Text or where applicable) and required in connection with the treatment of accidental bodily injury or sickness of myself or one of my eligible dependants. I declare that my statements in this expense reimbursement request are accurate and true.

On behalf of myself and my eligible dependants, I authorize my Students' Union and group benefit provider, The Campus Trust and any of its affiliates or re-insurers 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 dependants. 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 dependants are covered by, or are claiming benefits under the present group contract, or any modification, renewal or reinstatement thereof. I agree that a photocopy or electronic copy of this authorization is as valid as the original.

Date _____ Signature of Student _____ Telephone Number _____

Direct Deposit is now available! Register now at *www.studentbenefits.ca* to learn more!