# University Health Insurance Plan
# CLAIM FORM

**IMPORTANT:** Attach original receipts (not photocopies). Sections 1 to 3 must be fully completed.
Section 4 and 5 must be completed by Provider unless detailed invoice accompanies this claim form.

Clear

## SECTION 1 - UHIP MEMBER INFORMATION *(To be completed by UHIP member)*

| Last Name | First name | Certificate number or University ID |
|---|---|---|
| Kumar | Daman | 316103158 |

| Canadian Address (Street number and name) | Telephone number |
|---|---|
| 1285 countrystone drive | ( 519 ) 208 - 3459 |

| City | Province | Postal code |
|---|---|---|
| kitchener | ON | N2N3s4 |

## SECTION 2 - PATIENT INFORMATION *(To be completed by UHIP member or patient)*

| Last Name | First name | Date of birth (dd-mm-yyyy) |
|---|---|---|
| Kumar | Daman | 25 7 2005 |

Relationship to the member ☒ Self ☐ Spouse ☐ Child

☐ Female ☒ Male ☐ Non-binary ☐ Undisclosed

## SECTION 3 - AUTHORIZATION *(To be completed by UHIP member)*

Note: If payment is to be made directly to the provider, both authorizations (A & B) must be signed.

A. By submitting a claim to Cowan Insurance Ltd. (Cowan), I confirm that I understand and agree to all of the following:
I certify that the information provided for the claim(s) being submitted is true, accurate and complete and that I, my spouse and/or my dependants have received all goods or services as claimed. I understand and acknowledge that submission of a claim determined by Cowan to be false or misrepresented will be reported, together with any related information/documentation, to my plan sponsor. I understand and acknowledge that Cowan may refer any claims it has determined were falsely submitted to law enforcement authorities for possible prosecution. Cowan will pursue the recovery of any money that has been obtained improperly through false claim submission. I authorize any person or organization with Information, including any medical and health professionals, facilities or providers, professional regulatory bodies, any employer, group plan administrator, insurer, investigative agency, and any administrators of other benefits programs to collect, use, maintain and exchange this Information with each other and with Manulife, its reinsurers and/or its service providers including Cowan, for the purposes of Group Benefits plan administration, audit and the assessment, investigation and management of this claim (Purposes). I confirm that I am authorized by my dependants to consent to this authorization, on their behalf as if they were signing it themselves, and to disclose and receive their information, for the Purposes. I agree that my coverage may be denied or terminated because of my providing false, incomplete or misleading Information.
I agree to refund any monies or overpayments that I may owe in accordance with the provisions of the Group Benefits plan, and I authorize Cowan to deduct such monies from my future claims. I agree a photocopy, facsimile or electronic version of this authorization shall be as valid as the original. More detailed information concerning how and why Manulife and/or Cowan collects, uses and discloses my personal information is available at www.manulife.ca/planmember, or www.cowangroup.ca/home/privacy-policy/.
I understand that any Information provided to or collected by Cowan in accordance with this authorization, will be kept in a Group Benefits health file. Access to my Information will be limited to:

- Manulife employees, Cowan employees, representatives, reinsurers, and service providers in the performance of their jobs;
- persons to whom I have granted access; and
- persons authorized by law.

I have the right to request access to the personal information in my file, and, where appropriate, to have any inaccurate information corrected.

Date: 21 6 2024 Member's signature: Daman

B. I hereby authorize COWAN INSURANCE GROUP to make payment directly to the provider indicated below. In the event my claim(s) are declined by COWAN, I understand that I remain responsible for payment to the provider for any services rendered and/or supplies provided.

Date: 21 6 2024 Member's signature: Daman

## SECTION 4 - PROVIDER INFORMATION *(To be completed by provider)*

| Provider's name | Specialty |
|---|---|
| Rodica Cosma | clinic doctor |

| Address | Postal code |
|---|---|
| KW Walk-In Clinic, 100 The Boardwalk, Kitchener, ON | N2N0B4 |

| **Cowan Provider I.D. Number** | Telephone number |
|---|---|
| | ( 519 ) 279 - 4098 |

## SECTION 5 - STATEMENT OF SERVICES *(To be completed by provider)*

| Service date | Description of service | Provincial code (plus time units, if applicable) | Charge | Diagnosis |
|---|---|---|---|---|
| 21 6 2024 | PRIVATE VISIT | | $60.00 | Rashes |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

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

Date: 21 6 2024 Provider's signature: _____

NOTE: * ***Physicians and Hospitals*** must provide the diagnosis.

| **HOW TO SUBMIT YOUR CLAIM:** | **DIRECT ALL INQUIRIES TO:** |
|---|---|
| UHIP Members and Health Care Providers can submit via the online secure portals at:<br>Member: clients.cowangroup.ca<br>Provider: provider.cowangroup.ca<br>**or**<br>Mail us your claim form and receipts to:<br>Cowan Insurance Group<br>700-1420 Blair Place, Ottawa ON K1J 9L8 | Tel.: 1 833-377-UHIP (1 833-377-8447) Fax: 613-741-7771 |