guard.me® CANADA
EMERGENCY HEALTHCARE ACCESS CARD

Insured: Jumhar Chrysos Estepa Viernes
Student No: 301379795 Group #: 2886
Start Date: Jan 01, 2024 Policy # 10266612UCV
End Date: Aug 31, 2024
Organization: Centennial College

MDM GUARD CARD

EMERGENCY PROCEDURES
Contact the 24 Hour Emergency Assistance Number:
1. Within 24 hours of admission to Hospital, or if incapacitated, as soon as reasonably possible;
2. For any benefit where prior approval is required;
3. For inbound insureds on an Excursion, prior to incurring ANY medical expenses.

MESURES D'URGENCE
Appelez le numéro d'urgence disponible 24h/24h :
1. Dans les 24 heures ou le plus tôt possible en cas d'hospitalisation;
2. Pour tout authorisation préalable si cela s'avère nécessaire;
3. Si l'affilié est en voyage et avant qu'il n'entame des dépenses médicales.

Toll free North America / Numero gratuit en Amerique du Nord
1 888 756 8428

or collect anywhere else in the world / partout ailleurs dans le monde appeler le
1 905 752 6230

Prescription Medications and Emergency Dental ONLY / Pour les médicaments d'ordonnances et les soins dentaires d'urgence SEULEMENT

MDM GUARD CARD

For Pharmacy and Dental Office Inquiries ONLY / Pour les demandes de renseignements des pharmacies et des bureaux dentaires SEULEMENT

1-800-838-1531

PLEASE PRINT CLEARLY

guard.me Policy Number:	10266612UCV	**Coverage Start Date:**	Jan 01, 2024
Organization or School Name:	Centennial College	**Coverage End Date:**	Aug 31, 2024
Name of Insured/Patient:	Jumhar Chrysos Estepa Viernes	**Date of Birth:**	Dec 08, 2004

Payee Name _____ **Mailing Address** _____

City _____ **Province/State/Region** _____ **Zip/Postal Code** _____

Tel: _____ **Fax:** _____ **Email:** _____

○ **Cheque (Make cheque payable to)** ○ **Same as above** ○ **Different Address** _____

○ **Direct Deposit (Attach Void Cheque). Email address required** _____

1. **Do you have other insurance which covers medical expenses in Canada?** ○ **NO** or ○ **YES** **If yes, please provide details:**

2. **BC Students, if your claim is for services provided in a Hospital, please attach your valid study (or work) permit (if applicable).**

3. **Were you hurt in an accident?** ○ **NO** or ○ **YES** Tell us what happened, when and where the accident occurred, and if a vehicle or workplace was involved:

4. **Tell us WHEN and WHY you received treatment (below).** Please attach original bills and receipts with this Claim Form

Date of onset of sickness or injury (yyyy/mm/dd)	Date of Service (yyyy/mm/dd)	Cost/Currency	Describe the injury or illness that required the treatment (or Diagnosis)

FOR DIRECT BILLING BY MEDICAL PROVIDERS ONLY

For prompt reimbursement as detailed below, FAX this signed form to guard.me

○ **Rx Given** ○ **X-ray Ordered** ○ **Lab work Ordered** ○ **Other/Details**

Is this emergency treatment, medically necessary to identify and/or treat a new, acute, unexpected sickness? ○ **NO** or ○ **YES**

If you answer YES, we will reimburse eligible expenses to you directly.
If you answer NO, have the insured pay for this visit. Please call the below number if you have any questions.

Medical Provider's Name **PRINT** _____ Date _____ Medical Provider's Signature **(only required for direct payment)** _____

ATTACH ALL BILLS and MAIL TO:
guard.me Claims
80 Allstate Parkway
Markham, Ontario L3R 6H3
TEL: 1 888 756 8428 or 905-752-6230
www.guard.me
Medical Providers only Fax to:
1 866 329 6948 or 905 752 6235

I, the undersigned, declare that all the information I have provided in this Claim Form is true and complete. I acknowledge receipt of ***Travel Healthcare Insurance Solutions Inc. / guard.me***'s privacy statement. I authorize any hospital, physician, other medical provider or insurer to provide by any secure means my medical record to ***Travel Healthcare Insurance Solutions Inc. / guard.me*** and its insurers for the purpose of administering claims. All information is to be held in complete confidentiality and is not to be released to any party apart from those listed above. Use of my email address will be restricted to insurance inquiries unless I initiate email contact. A photocopy or facsimile transmission of this Claim Form is as valid as the original. I assign my right to payment to the party indicated above.

_____ Insured/Legal Guardian (Signature)

_____ Date

Underwritten by: Old Republic Insurance Company of Canada