STUDENTCARE

THIRD PARTY AUTHORIZATION FORM

STUDENT INFORMATION

Full Name: _____

Student ID: _____

Date of Birth: (MM/DD/YYYY) _____

My signature below indicates that I agree to all of the following:

I authorize the named individual to act on my behalf regarding any inquiries relating to the Health & Dental Plan. This authorization allows the named individual to provide any information to Studentcare as it relates to my Health & Dental Plan. This authorization also allows Studentcare to provide information to the named individual as it relates to my Health & Dental Plan.

This authorization is valid for the following period of time (please choose only one option):

☐ Case Reference Number: _____

☐ The Following Dates: (MM/DD/YYYY) _____

☐ The Duration of my Studies at (please indicate institution): _____

AUTHORIZED INDIVIDUAL

Full Name: _____

Relationship to Member: _____

Contact Information: _____

Student's Signature: _____ Date: (MM/DD/YYYY) _____

Return completed Third Party Authorization Form to:

Studentcare
1200 McGill College Avenue, Suite 2200
Montreal, QC H3B 4G7

or

FAX: 514 789-8734