

Morcare is becoming

ALUMO International Student Health Care Claim Form

All claims must be submitted to Morcare at the address below within 6 months from the date on which the expenses are incurred or November 30th, 2026; whichever is earlier. Claimants must provide a valid Canadian address for reimbursement. Claimant reimbursement cheques will not be issued to a non-Canadian address.



Download the Morcare app to submit claims online or send your claim to the following email: claims@morcare.ca
Secondary option via mail: Morcare Insurance, 2255 Sheppard Ave East, Suite 202, 2nd Floor, Atria 1, Toronto, ON M2J 4Y1



SECTION 1A. STUDENT INFORMATION

PLEASE PRINT CLEARLY

Please provide the following information:

Morcare is becoming
ALUMO International Student Insurance Card

Please refer to your Alumo Medical Card

Date of Birth

Male Female

Institution (College/University)

Last Name First Name

DRUG, DENTAL, & EXTENDED HEALTH GROUP NUMBER:

Certificate ID

HOSPITAL, PHYSICIAN & ACCIDENT POLICY NUMBER:

Certificate ID

TELEPHONE NUMBER

EMAIL ADDRESS

CANADIAN ADDRESS (STREET NUMBER AND NAME)

APARTMENT / UNIT NUMBER CITY

PROVINCE POSTAL CODE

SECTION 1B. DEPENDENT INFORMATION (SPOUSE OR CHILD OF STUDENT)

PLEASE PRINT CLEARLY

Complete this section only if you are submitting a claim for a dependent.

List the names of all persons for whom you are claiming expenses. Add up all the receipts and insert the total amount claimed. Ensure each receipt clearly indicates the type of expense being claimed. Attach ORIGINAL receipts indicating that you have paid the provider in full (photocopied bills/receipts are not acceptable).

LAST NAME	FIRST NAME	Gender	Date of birth (dd-mm-yyy)	Relationship to you	IF OVER 18 YEARS OF AGE		Amount claimed
					Full-time student	Handicapped child	
					<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	\$
					<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	\$

SECTION 2. INFORMATION ABOUT YOUR CLAIM

PLEASE PRINT CLEARLY

Please describe the reason for your claim and your symptoms.

For example: stomach ache, migraine, broken bone, fever, eye infection, eye glasses/contacts, massage therapy, prescription drugs, etc.

Date first diagnosed with symptom(s) (dd-mm-yy):	TOTAL AMOUNT OF CHARGES
	\$

Is your claim related to pregnancy? ☐ No ☐ Yes If yes, please provide due date (dd-mm-yy):

Is your claim the result of an accident? ☐ No ☐ Yes
If yes, please explain what happened:

DATE OF ACCIDENT (DD-MM-YYYY)

Is your claim related to any of the following?

☐ Co-op Work Placement for School (Attach co-op placement confirmation) ☐ School Program (ECE, Nursing etc.) (Attach notice of medical requirements)

Please carefully read this entire page if you are claiming medical expenses under your OHIP Alternative Coverage.

Examples Include:

- Hospital visits/hospitalization
- Walk in clinic
- Ultrasound/x-rays
- Emergency room visits
- Physician visit
- Blood tests

SECTION 3. PARAMEDICAL EXPENSES

PLEASE PRINT CLEARLY

This section to be completed if claiming for paramedical services, x-rays, or laboratory fees.

Date service rendered (dd-mm-yyy)	Nature of illness or injury	Claim description	Amount charged	Name of Doctor prescribing service	Date first consulted for condition (dd-mm-yyy)

SECTION 4. PHYSICIAN'S ACCOUNT RECORD (FOR THE COMPLETION BY THE PHYSICIAN)

PLEASE PRINT CLEARLY

Your physician must complete this section if claiming for hospital, medical expenses or physician services

PHYSICIAN'S NAME		PROVIDER ID NUMBER		TELEPHONE NUMBER	
ADDRESS OF PROVIDER (STREET NUMBER AND NAME)		SUITE NUMBER	CITY	PROVINCE	POSTAL CODE
DATE PATIENT FIRST CONSULTED YOU WITH SYMPTOM(S) (DD-MM-YYYY)					

Service date (dd-mm-yyyy)	Description of service	OHIP Procedure code (plus time units, if applicable)	Charge	Diagnostic code

DIAGNOSIS (DESCRIBE COMPLICATIONS, IF ANY) / PROCEDURES (USE EXACT WORDING OF SCHEDULE OF FEES)

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

X

PHYSICIAN'S SIGNATURE (OR STAMP)

DATE (DD-MM-YYYY)

Industrial Alliance Insurance and Financial Services Inc.**Medical Services under OHIP Alternative (eg. Hospital, Physician services, x-rays, blood tests, etc.)**

On behalf of myself, and/or spouse, and/or any minor insured, I RELEASE the information contained in this Claim Form to Industrial Alliance Insurance and Financial Services Inc. (the "Company") and ACKNOWLEDGE that this information will be used to assess, process and administer this claim and policy coverage.

I hereby authorize the Company, for the purposes of investigation, evaluation and administration of my claim:

- to gather only the information necessary for the above specified purposes from any person or organization that has personal information relating to me, including other insurers, reinsurers, and financial institutions; physicians, medical institutions and healthcare providers; employers or administrators of group benefits; agents or brokers; investigating and credit reporting agencies, and all persons or organizations likely to have personal information relevant to my claim.
- to disclose and exchange only the necessary personal information the Company has relating to me to the above persons and organizations.

I understand that the personal information obtained by the use of this authorization will be used by the Company in the investigation, administration and evaluation of a claim for benefits. Any information obtained will not be released by the Company, except to persons or organizations performing business or legal services in connection with my claim, or as may be otherwise lawfully required or as I may further authorize. I confirm that a photocopy or electronic copy of this authorization shall be valid as the original. I declare that the information provided in this form is accurate and any statements provided in any personal or telephone interview concerning this claim will be true and complete. I agree that all such statements form the basis for any benefit approved as the result of this claim.

ClaimSecure**For Extended Health Services (eg. Prescription drugs, physiotherapy, ambulance, eyeglasses/contact lenses, etc.)**

I certify that the above information is true and complete and that the above charges were for goods and services received by me, my spouse or my eligible dependents. I certify that I am authorized to disclose and receive information about my spouse and/or dependents for purposes of assessing and paying a benefit if any. I acknowledge that unless assigned to the service provider, any reimbursement of the above charges and explanation of such amounts paid will be provided to the benefit plan member. I authorize ClaimSecure, healthcare professionals, insurers, administrators of government or other benefit plans, and other service providers working with ClaimSecure to exchange necessary information regarding this claim to administer my health benefit plan.

PLEASE ATTACH ALL ORIGINAL INVOICES

Important - Check one of the following boxes:

<input type="checkbox"/>	PAYMENT IS TO BE MADE TO THE STUDENT	<input type="checkbox"/>	INCLUDE PROOF OF PAYMENT	<input type="checkbox"/>	PAYMENT IS TO BE MADE TO THE HOSPITAL/DOCTOR/CLINIC
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PAYMENT METHOD: ☐ CHEQUE ☐ ELECTRONIC FUNDS TRANSFER (FOR EFT PAYMENTS, COMPLETE FIELDS BELOW AND CHECK FOR ACCURACY)

*CANADIAN BANK ACCOUNTS ONLY

CLICK HERE TO VIEW EXAMPLE

BANK NAME	ACCOUNT HOLDER NAME	PAYEE NAME (IF DIFFERENT FROM ACCOUNT HOLDER)	
ACCOUNT HOLDER ADDRESS			
PAYEE EMAIL	TRANSIT NUMBER	FINANCIAL INSTITUTION NUMBER	ACCOUNT NUMBER

X

NAME (PLEASE PRINT)

STUDENT ID

DATE (DD-MM-YYYY)

SIGNATURE OF PATIENT/GUARDIAN (YOU MUST SIGN HERE)

When your claim is received...

Please note that all claims are subject to standard adjudication processing. You should expect a response within 30 days from from date claim is received by Morcare Insurance. Our response would be one of the following: (A) Payment or Notification of Payment to a Provider; (B) Request for more information if required; (C) Acceptance or Denial of the claim with reasons.

SECTION 6. SUBMISSION

Please send your claim to the following email: claims@morcare.ca

Secondary option via mail: Morcare Insurance, 2255 Sheppard Ave East, Suite 202, 2nd Floor, Atria 1, Toronto, ON M2J 4Y1

PROTECTING THE PRIVACY OF YOUR PERSONAL INFORMATION

Industrial Alliance Insurance and Financial Services Inc. (the "Company") recognizes and respects every individual's right to privacy. Personal information about you is kept in a confidential claim file at the offices of the Company or of an organization authorized by the insurer in a secure area. We limit access to information in your files to our staff or persons authorized by the Company who require this access to perform their duties, to persons to whom you have granted access, and to persons authorized by law. We use this information to investigate, assess and administer your claim and the terms of the insurance contract provisions. You may access the personal information contained in your file and correct any inaccurate information. Any personal health information will be provided to you through a medical practitioner of your choice. To view your personal information please send a request in writing to the attention of the Claims Department at Industrial Alliance Insurance and Financial Services Inc., 2165 Broadway W, PO Box 5900, Vancouver, BC, V6B 5H6, together with the name of the medical practitioner.