150 King St West, Suite 602 – PO Box 75
Toronto, ON, Canada, M5H 1J9
1.800.360.3234 • 1.416.730.8488
www.americas.msh-intl.com

Consent Form

Dear parent/legal guardian,

As a student in the international program at _____
Name of School/School District
your child receives emergency medical insurance coverage through StudyInsured™, the student business arm of MSH International (Canada) Limited.

MSH/StudyInsured™ is mandated to follow privacy rules and regulations regarding the personal health information of insured members worldwide. This means that no information about a student health insurance case or claim can be released to any third party. However, students may request that school staff help to manage their medical case, including but not limited to explaining claims decisions, obtaining medical documents or claim reimbursements, and/or repatriating members to their home country after serious illness or injury.

To be compliant, we request your authorization to ensure that we have permission to share information about your child's medical care and insurance claim(s) with a school or school board staff member assigned to assist students with insurance-related matters.

While your cooperation is appreciated, it is not mandatory. Your child will receive the same level of care regardless of your participation in authorizing the release of information. If you do not wish to sign this form, authorization to release information may be requested of you at a later date or at the time of a claim.

Please carefully read the release statement below. Once you have signed and dated it, click the Submit button to email it to studentteam@studyinsured.com . Alternatively, you may attach this form to an email to studentteam@studyinsured.com with the subject line: **Consent Form - [Name of school/school district your child attends].** (Example: "Consent Form - Mission Public Schools")

We ask that you refrain from including personal information in the email. Any personal identifying information may be attached and password-protected as required.

Should you have any questions or concerns, please do not hesitate to contact us.

Sincerely,
studyinsured™

Toronto Office
150 King St West, Suite 602 – PO Box 75
Toronto, Ontario M5H 1J9, Canada

Calgary Office
Suite 2900, 605 5th Avenue S.W.
Calgary, Alberta T2P 3H5, Canada

Website | LinkedIn | Twitter | Facebook | Instagram

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AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH RELATED INFORMATION

This authorization complies with HIPAA Privacy Law.

I/we, the legal parent(s) or guardian(s) grant MSH International (Canada) Ltd. ("MSH") and international student department staff at _____ ("the School") the explicit right to authorize medical treatment deemed to be necessary by a member of the medical profession, in a hospital, medical clinic or doctor's office, including but not limited to any surgical procedures.

In the case that said medical expenses exceed that of the coverage provided by the insurance policy, all of the said expenses will be borne by the undersigned participant and natural parent or guardian. We will pay all outstanding bills as soon as they are brought to our attention.

I/we authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, treatment, or services to the insured or on the insured's behalf within the past 10 years ("Providers") to disclose the insured's entire medical record and any other personal health information concerning the insured to MSH and the international student department staff at the School. This includes information on the diagnosis, or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the treatment of mental illness and the use of alcohol, drugs, and tobacco. By placing our signatures below, I/we acknowledge that any agreements that have been made to restrict the insured's personal health information do not apply to this authorization and I/we instruct the Providers to release and disclose the insured's entire medical record without restriction.

This personal health information is to be disclosed under this Authorization so that MSH may:

1) Underwrite my application for coverage, make eligibility, risk rating, policy issuance, and enrollment determinations;

2) Obtain reinsurance;

3) Administrate claims and determine or fulfill responsibility for coverage and provision of benefits;

4) Administer coverage;

5) Conduct other legally permissible activities that relate to any coverage the insured has (or have) applied for with MSH.

This personal health information is also to be disclosed under this Authorization so that the international staff at the School may:

1) Assist in setting up medical appointments,

2) Submit and manage claims and reimbursements, and

3) Assist the insured with any problems that arise in relation to any coverage the insured has (or have) applied for with MSH.

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This Authorization shall remain in force for 12 months following the date of my/our signature below, and a copy of this Authorization is as valid as the original.

I/we understand that I/we have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to the MSH Privacy Officer at:

MSH International (Canada) Ltd.
Attention: Privacy Officer
150 King St. West, Suite 602
Toronto, ON, M5H 1J9
Canada

I/we understand that a revocation is not effective to the extent that any of the Providers have relied on this Authorization or to the extent that MSH or the School has a legal right to contest a claim under the insured's insurance policy, or to contest the policy itself. I/we understand that any information that is disclosed pursuant to this authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I/we understand that the Providers may not refuse to provide treatment or payment for health care services if I/we refuse to sign this authorization. I/we further understand that if I/we refuse to sign this authorization to release the insured's complete medical record, MSH and the School may not be able to process the insured's application, or if coverage has been issued may not be able to make any benefit payments. I/we understand that I/we will receive a copy of this Authorization upon request.

_____
Signature of Parent/Legal Guardian

_____
Full name of Parent/Legal Guardian

_____
Full name of Insured member

_____
Date (MM/DD/YYYY)

SUBMIT