

**Pioneer Management Systems**  
**Medical and Prescription Drug Claims Form for Students Studying Abroad**

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**Student Information**

Student Name \_\_\_\_\_ SIS# \_\_\_\_\_  
Last First MI

(Home) Student Street Address \_\_\_\_\_

(Home) City, State & Zip \_\_\_\_\_

Claim is for \_\_\_\_\_  
(Name of Claimant)

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**College Information**

Wheaton College  
Center for Global Education  
26 E. Main Street, Norton, MA 02766  
508-286-4950 (phone)  
508-286-4975 (fax)

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**Other Insurance Information**

Are you covered by any other Group Health Benefits or any Federal, State or other Government Agency Plan? If yes, please complete the following:

Through whom was/is your coverage provided? (i.e., parent)

\_\_\_\_\_  
Name Relationship

Name of Insurance Company \_\_\_\_\_

Insurance Company Address \_\_\_\_\_

Plan/Group Number \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Is this claim the result of an accident?  Yes  No If yes, give the date of accident \_\_\_\_/\_\_\_\_/\_\_\_\_

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**Student Authorization**

**PLEASE READ AND SIGN:** I certify, under penalty of perjury, that all information provided on this form is true to the best of my knowledge. I certify that all attached receipts are for prescription drugs and/or medical services obtained for myself. I hereby authorize any physician, hospital, insurance company, employer or organization to release any information regarding the medical history, treatment or benefits payable for this claim.

Student's Signature X \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**Pioneer Management Systems, Inc.** • 330 Whitney Avenue • Holyoke, MA 01040  
Fax (413) 534-0687 • Toll Free (877) 868-9060

**PLEASE STAPLE ALL PRESCRIPTION DRUG AND/OR MEDICAL RECEIPTS TO THIS FORM. IF BILLS ARE NOT TRANSLATED INTO ENGLISH, PLEASE PROVIDE A DESCRIPTION OF THE ACCIDENT OR SICKNESS.**

