Industrial Alliance Insurance and Financial Services Inc.
Claims Department
400 – 988 Broadway W, PO Box 5900, Vancouver, BC V6B 5H6
Telephone: 1-800-266-5667 Fax: 1-866-913-3620
Email: claims@ia.ca www.solutionsinsurance.com

Family Accident Reimbursement Plan

CLAIMS INFORMATION AND DOCUMENTS REQUIRED

- **The Claimant's Statement, invoices and other supporting documents (listed below) must be submitted within 90 days of the accident and no later than one year, whether or not expenses are incurred.**
- **A claim form must be completed for each injured member wishing to claim benefits under the policy.**
- **The claimant is responsible for having the required forms completed at their own expense.**
- **To ensure prompt handling of your claim, please ensure that all claims documents are fully completed and the required supporting documentation provided at the time of claim.**
- **Coordination of benefits for dental, hospital, paramedical, eyewear and emergency care expenses: You must always submit claims for reimbursement to other plans first (public, private or group insurance plans). Once you receive a copy of the other insurance company's Explanation of Benefits, please send them to us to complete your claim.**
- **Please note that this list is not exhaustive and other documents may be required to complete your claim.**
- **Original receipts are not required, however, please retain originals for 12 months following the date you submitted the claim.**

BENEFIT CLAIMING FOR	SUPPORTING DOCUMENTS REQUIRED
Dental Treatment	• Completed Dentist's Statement • Standard Dental Claim form (original) completed by the Dental Provider
Eyewear – As a result of accidental injury only • Repair or replacement of existing eyewear • Requiring purchase when not previously worn	• Completed Physician's Statement (MD)
Fracture, Dislocation or Surgery	• Completed Physician's Statement
Hospital, Paramedical, Counselling and Prosthetics	• Completed Physician's Statement (MD) • Physician's Referral required for: Paramedical and Counselling benefits.
Travel and Transportation	• Transportation details (date, place of departure, place of arrival, number of kilometers travelled, original receipts
Dismemberment or Total and Permanent Loss of Use	• Completed Physician's Statement (MD) • Supporting medical records from your physician
Death, Disability or Critical Illness Claims or any other benefits	• Please contact us directly for the necessary claims documents: 1-800-266-5667 or claims@ia.ca

Please return all claim forms and supporting documentation to:

INDUSTRIAL ALLIANCE INSURANCE AND FINANCIAL SERVICES INC.
CLAIMS DEPARTMENT

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Claimant's Statement

For rapid processing of your claim, please send the duly completed claim form. It will be returned to you if any information is missing

CLAIMANT (Applicant, father, mother or guardian)

Policy Number | Member ID | Last Name | First Name

Street Address | City | Province | Postal Code

Telephone | Cell | Email

School Attended

IDENTITY OF THE INJURED PERSON

Last Name | First Name | Sex ❑ M ❑ F

Date of Birth (yyyy-mm-dd) | Provincial Health Card #

DESCRIPTION OF THE ACCIDENT AND RESULTING INJURIES

Date of Accident (yyyy-mm-dd) | Location of Accident | Time ❑ A.M. ❑ P.M.

How did the accident occur? Please provide details of accident (i.e. place, injury sustained).

Name and Address of Dentist or Physician first attended

COORDINATION OF BENEFITS

Note: You must first submit your claim to the other insurer then send us a copy of the settlement documentation along with a copy of the invoice.

Are you covered by another insurance plan (employer or other insurance) ❑ Yes ❑ No

Other Insurance Company | Contract Number

Name of Insured | Certificate Number

Are the benefits under this claim covered by the other insurance? ❑ Yes ❑ No

Have you submitted this claim to the other insurance company? ❑ Yes ❑ No

If "Yes" to above, please provide the Explanation of Benefits from the other insurance company.

AUTHORIZATION AND DECLARATION

I hereby CERTIFY that the information contained in this Claim Form is true and complete to the best of my knowledge.
On behalf of myself 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 AUTHORIZE any health care provider, insurance company, school or school board, employer, or other person or other organization to disclose to the Company any medical information, information regarding charges, or other information that the Company may need in their assessment of this claim.
I AUTHORIZE the Company to exchange the information detailed in this Claim Form and other information contained in files related to this claim or coverage with any of the parties identified in the previous paragraph for the purposes listed above, or as authorized by me, or as legally required.

Signature of Insured Patient or Parent or Legal Guardian | Date Signed (yyyy-mm-dd)

PRIOR TO SUBMITTING YOUR CLAIM

Please refer to the Claims Information and Documentation Required page to ensure that you provide all the necessary documents applicable to your claim.
*** Ensure that the benefit claimed is covered in your contract.**

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Family Accident Reimbursement Plan

Physician's Statement

TO BE COMPLETED BY A MEDICAL DOCTOR (M.D.)
FOR MEDICAL EXPENSES, DISMEMBERMENT OR TOTAL AND PERMANENT LOSS OF USE

Date of Accident (yyyy-mm-dd)

Date of first attendance for this injury (yyyy-mm-dd)

Nature of Injury

❑ Fracture Location and Type

❑ Other Injury Location and Type

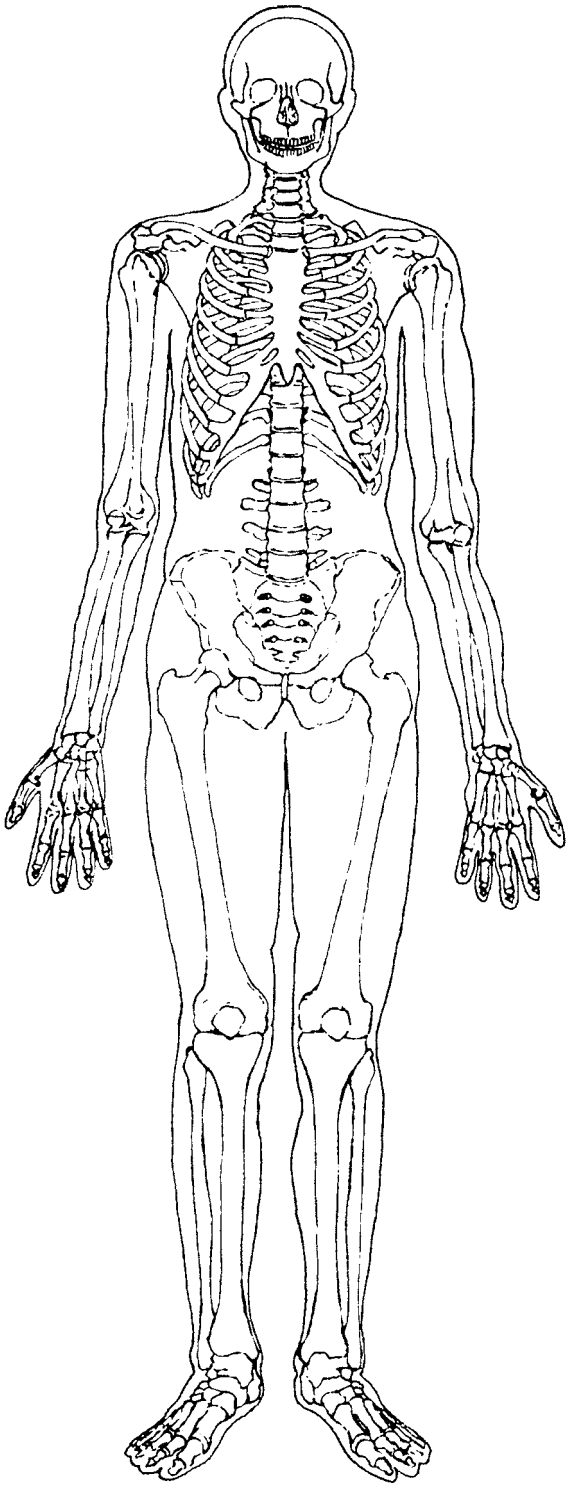
Visual Injury ❑ Yes ❑ No

If "Yes", please provide details.

Was surgery required? ❑ Yes ❑ No

Surgery Date (yyyy-mm-dd)

General Anesthetic ❑ Yes ❑ No



Please also complete this section if patient's claim is for Dismemberment and Total and Permanent Loss of Use.

Nature of Loss? State right or left on chart, please mark point of any amputation. ➔➔➔

What evidence of trauma did you find?

Give degree of loss:

Is loss permanent and irrecoverable? ❑ Yes ❑ No

Was injury sufficient to produce total and permanent loss? ❑ Yes ❑ No

If "Yes", please provide supporting medical documents (i.e. specialist, consultation, operative & rehabilitation reports).

Was claimant hospitalized? ❑ Yes ❑ No

Hospital Name

Date admitted (yyyy-mm-dd)

Names and addresses of other physicians or surgeons, if any, who attended claimant

Physician Name (Please print)

Address

Telephone

Physician Name (Please print)

Address

Telephone

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE.

Physician Name (Please print)

Address

Telephone

Signature

Date Signed (yyyy-mm-dd)

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Dentist's Statement – Dental Care

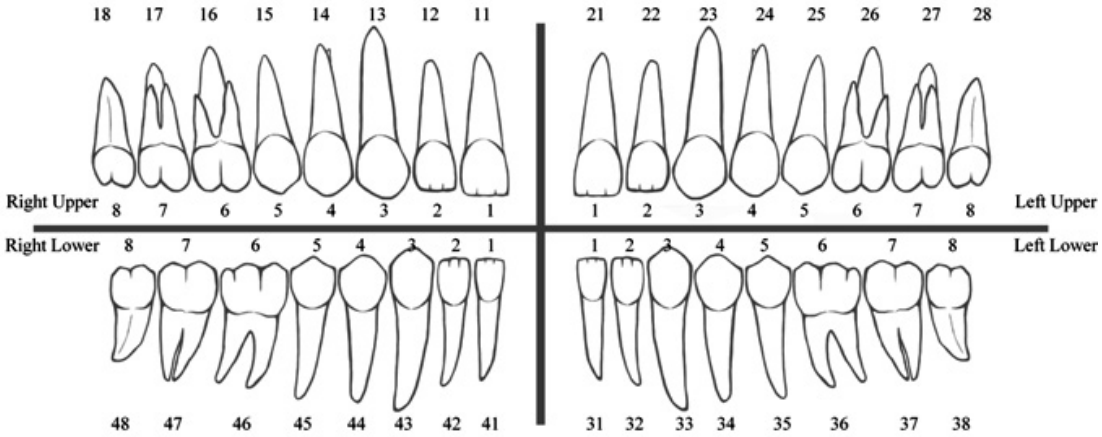
THIS SECTION IS TO BE COMPLETED BY THE DENTIST

Date of Dental Accident (yyyy-mm-dd)

Date of the first visit for this accident (yyyy-mm-dd)

Identification of the damaged tooth/teeth:

Please provide tooth number(s) below and mark teeth injured on diagram ➔



Were the teeth whole and sound prior to the accident? ❑ Yes ❑ No If "No" please describe below.

State of injured tooth/teeth after the accident (describe the damage sustained):

Immediate dental treatment required as a direct result of the accident:

If future dental treatment is required as a direct result of the accident please provide an estimation of when treatment will be required (tooth codes, procedure codes and estimated date). Please attach Pre-Determination form.

NAME AND ADDRESS OF DENTIST

Dentist's Name (Please print)

Address

Telephone

Signature

Date Signed (yyyy-mm-dd)