iA Financial Group

CLAIM FORM
MEDICAL EXPENSES

GROUP INSURANCE

Depending on your province of residence, please submit form to:

Quebec
Group Health and Dental Claims
PO Box 800, Station Maison de la Poste
Montreal, Quebec H3B 3K5

Ontario, Atlantic and Western Provinces
Group Health and Dental Claims
PO Box 4643, Station A
Toronto, Ontario M5W 5E3

☐ Claim ☐ Estimate

1. PRIMARY MEMBER INFORMATION

Member's last name _____ First name _____

Group policy no. _____ Certificate no. _____ Company/Association name _____

Date of birth (Y M D) _____ Sex: ☐ M ☐ F Language: ☐ English ☐ French

Preferred method of contact for the purpose of claims resolution:

☐ Phone _____ ☐ Email address _____

Complete this section only if your information has recently changed.

Member's address _____ Postal code _____

2. COORDINATION OF BENEFITS (Complete this section only if your spouse or dependent children are covered by another group plan.)

- If your spouse or dependent children are covered under their own group plan for medical benefits, the claim must first be submitted to his/her group insurance carrier. You may subsequently submit a claim to Industrial Alliance Insurance and Financial Services Inc. for the unpaid portion, if applicable.
- If your insured dependent children are covered under your plan as well as under your spouse's group plan, the claim must be submitted to the plan of the parent whose birthday comes first during a calendar year.

Is your spouse or dependent child(ren) covered by another group plan for medical benefits? ☐ No ☐ Yes, please complete the information below.

Health Coverage: ☐ Individual ☐ Family, name of insured spouse/child _____ Date of birth (Y M D) _____

Are you claiming any expenses for your spouse or dependent children that are **NOT** covered under their plan?

☐ No ☐ Yes, please specify the benefit: _____

If your spouse's group insurance carrier is also Industrial Alliance Insurance and Financial Services Inc., do you want us to apply coordination of benefits?

☐ No ☐ Yes, please specify: Spouse's group policy no. _____ Certificate no. _____

3. MEDICAL EXPENSES

- To ensure the complete resolution of your claim, please provide the required information as outlined on the reverse side of this form.
- **Attach the original receipts and keep a copy for income tax purposes and the coordination of benefits. The receipts will not be returned and they will be destroyed 60 days after the received date.**

Name (One line per claimant)	Relationship to member	Date of birth (Y M D)	For children 18 and over (or according to your plan)			Total expenses (per claimant)
			Handicapped child No Yes	Full-time student No Yes	Name of school	
			☐ ☐	☐ ☐		$
			☐ ☐	☐ ☐		$
			☐ ☐	☐ ☐		$
			☐ ☐	☐ ☐		$

If the claim is the result of an accident, please specify type of accident (details on reverse side, if applicable): ☐ Work ☐ Motor vehicle

Date of accident (Y M D) _____ ☐ Other _____

4. MEMBER CONFIRMATION/AUTHORIZATION

I HEREBY CONFIRM:

1. that the information contained in this claim form is true and complete to the best of my knowledge.
2. that the persons for whom I am making a claim are eligible and that if the claim is being made on behalf of a dependent, I am AUTHORIZED to disclose information about him/her with respect to the claim.

On behalf of myself and my dependents:

1. **I CONSENT TO THE RELEASE** of the information contained in this claim form to Industrial Alliance Insurance and Financial Services Inc. (the "Company"), its employees, agents, reinsurers, service providers and other organizations working with the Company for the purposes of underwriting, administration and processing of the claim.
2. **I AUTHORIZE** any healthcare provider or professional, medical organization, insurance or reinsurance company, workers' compensation board, the policyholder, my employer, as well as any other person, private or public organization or institution to disclose to the Company, its employees, agents and service providers any information regarding the treatment and expenses incurred which they may need in the assessment of the claim.
3. **I UNDERSTAND AND AUTHORIZE** that in the event there is reasonable suspicion of or any evidence of fraud or abuse regarding the claim, the Company will have the right to use and exchange any information related to the claim with any relevant regulatory, investigative or government body, any healthcare provider or professional medical organization, insurance company or reinsurer, the policyholder, my employer or any other party as provided by law for the purpose of investigating any such fraud or abuse.

I UNDERSTAND that personal information may be subject to disclosure to those authorized under the applicable laws within or outside of Canada.
I AGREE that a photocopy of this Confirmation/Authorization shall be as valid as the original.

Member's signature **X** _____ Date (Y M D) _____

CLAIMS SUBMISSION GUIDELINES

Medical benefits cover expenses for the following (which may vary according to your plan):

- Drugs
- Paramedical services
- Hospital rooms
- Vision care
- Medical appliances
- Ambulance transportation fees
- Travel insurance

For specific information, please consult your benefits booklet.

GENERAL INFORMATION

Industrial Alliance Insurance and Financial Services Inc. forms	• Other claim forms, including HSA forms, questionnaires and more information can be found on our website at **ia.ca**.
Coordination of benefits	• This establishes the order in which two or more insurance companies will pay benefits for the same claim (maximum 100%). • For detailed instructions and scenarios regarding coordination of benefits, please refer to the "Coordination of Benefits Guide available" on our website.
Claims related to a work or motor vehicle accident	• If your claim is related to a work accident, submit the initial claim to your provincial Workers' Compensation Board if applicable. • If your claim is related to a motor vehicle accident, submit the initial claim to your motor vehicle insurance, if applicable.
Expenses incurred outside of Canada	• Expenses incurred outside of Canada are handled by CanAssistance. For inquiries or questions, contact CanAssistance at **1-800-203-9024**. The travel insurance claim forms from CanAssistance, specific to your province of residence, can be found on our website at **ia.ca**.

CLAIM REQUIREMENTS

Original detailed receipts should include the following:	• Claimant's full name • Date, cost and type of treatment • Supplier or provider's name and credentials
Paramedical services (e.g. massage therapy, physiotherapy, chiropractic, etc.)	• Original detailed receipt including medical referral if required by your group policy
Foot orthotics	• Original detailed receipt • Casting technique • Credentials of qualified health practitioner who performed the casting (chiropodist, chiropractor, orthotist, pedorthist, physiotherapist or podiatrist)
Orthopedic shoes	• Original detailed receipt • Medical referral from a medical doctor, podiatrist, chiropodist, physiotherapist or chiropractor
Hospital beds & wheelchairs	• Original detailed receipt including breakdown of charges • Medical referral with diagnosis and symptoms • Expected length of time required • Purchase date of previous appliance, if applicable
Orthopedic appliances (e.g. knee & back braces)	• Original detailed receipt specifying the type of appliance • Medical referral with diagnosis and symptoms • Expected length of time required
Nursing care	• The nursing care benefit requires pre-approval from us. Download and complete the questionnaire and submit it to Industrial Alliance Insurance and Financial Services Inc. You can find the questionnaire on our website.

If you have any questions or concerns, please contact our Customer Service at 1-877-422-6487.