INDUSTRIAL ALLIANCE
INSURANCE AND FINANCIAL SERVICES INC.

www.inalco.com

GROUP INSURANCE

Please submit form to: Group Insurance, Claims Department
PO Box 4643, Station A
Toronto, Ontario M5W 5E3

CLAIM FORM
MEDICAL EXPENSES

Policyholder's name

Policy no. Division no. Class no.

Member's last name First name

Certificate no. Date of birth (Y M D) Sex: ❑ M ❑ F Language: ❑ E ❑ F

POLICYHOLDER'S STATEMENT *(To be completed by the plan administrator, only if your group is self-administered)*

	Member (Y M D)	Spouse (Y M D)	Child (Y M D)
Effective date			
Termination date			

Authorized representative ______ Date ______

COORDINATION OF BENEFITS

Are you or your dependent covered by another group plan? ❑ No ❑ Yes **Specify:**

Name of insurance company ______ Policy no. ______ Coverage: ❑ Individual ❑ Family

Name of spouse ______ Date of birth (Y M D)

MEDICAL EXPENSES

(Attach the original receipts and keep a copy for income tax purposes and the coordination of benefits. If there are three originals, please enclose Original 1.) ***The receipts will not be returned and they will be destroyed 60 days after receipt.***

NAME (member or insured dependent)	RELATIONSHIP TO THE MEMBER	DATE OF BIRTH (Y M D)	18 and over Full-time student No	Yes	Handicapped child No	Yes	CHILDREN 18 AND OVER Name of school	TOTAL
			❑	❑	❑	❑		$
			❑	❑	❑	❑		$
			❑	❑	❑	❑		$
			❑	❑	❑	❑		$

If there are expenses for the rental or purchase of an appliance, please attach a letter from your physician describing the diagnosis.

Expenses following an accident? ❑ No ❑ Yes Nature of accident: ❑ Work ❑ Motor vehicle ❑ Crime victim ❑ Other ______

Date of accident (Y M D) Place of accident ______

AMBULANCE TRANSPORTATION FEES *(Enclose the receipt from the ambulance service)*

Reason for ambulance service ______

Place of pick-up: ❑ Home ❑ Work ❑ Other Specify ______

EXPENSES INCURRED OUTSIDE THE PROVINCE OF RESIDENCE

If the medical expenses were incurred outside the province of residence, please complete "MEDICAL EXPENSES INCURRED OUTSIDE THE PROVINCE OF RESIDENCE" (F54-371A). To obtain a copy of this form, please call (514) 499-3747 or 1-800-203-9024 if you are calling from outside the Montreal area.

MEMBER CONFIRMATION/AUTHORIZATION

I HEREBY CONFIRM that the information contained in this Claim Form is true and complete to the best of my knowledge.

I HEREBY CONFIRM that the expenses were incurred by myself or by one of my insured dependents and are required in connection with the treatment of a medical condition.

If this claim is being made on behalf of my spouse and or/dependent children, **I CONFIRM** that **I am AUTHORIZED** to disclose information about them with respect to this 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, its employees, agents, reinsurers and service providers for the purposes of underwriting, administration and processing of the claim; and

(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, public or private organization or institution to disclose to Industrial Alliance, its employees, agents and service providers any information regarding the treatment and charges incurred which they may need in the assessment of the claim.

I AUTHORIZE the use of my Social Insurance Number as an identification number where it is required for the administration of the group policy.

I AGREE that a photocopy of this Confirmation/Authorization shall be as valid as the original.

Member's signature X ______ Date ______

Address ______ Postal code

Tel. home ( ) Tel. work ( )

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