INDUSTRIAL ALLIANCE
INSURANCE AND FINANCIAL SERVICES INC.

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www.inalco.com

GROUP INSURANCE

CLAIM FORM MEDICAL EXPENSES

According to 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

Policy no. _____ Policyholder's name _____

Member's last name _____ First name _____

Certificate no. _____ Date of birth Y M D _____ Sex: ☐ M ☐ F Language: ☐ E ☐ F

COORDINATION OF BENEFITS

Are you or your dependents covered by another group plan? ☐ No ☐ Yes Specify:

Name of insurance company _____ Policy no. _____ Coverage: ☐ Individual ☐ Family

Name of spouse or child _____ 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	CHILDREN 18 AND OVER: Handicapped child No Yes	CHILDREN 18 AND OVER: Full-time student 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 and circumstances 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 F54-371A - MEDICAL EXPENSES INCURRED OUTSIDE THE PROVINCE OF RESIDENCE. 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.

(3) I UNDERSTAND AND AUTHORIZE that in the event there is reasonable suspicion of or any evidence of fraud or abuse regarding the claim, Industrial Alliance 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 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 Y M D _____

Address _____ Postal code _____

Tel. home _____ Tel. work _____ Extension _____