iA Financial Group

CLAIM FORM
Accident / health insurance benefit

F13-1110A

1. PRIMARY MEMBER INFORMATION

Member's name: _____ Contract number: _____

Phone no.: _____ Email address: _____

Date of birth: Y Y Y Y M M D D _____

Complete this section only if your information has recently changed.

Address: _____ Postal code: _____

2. PATIENT INFORMATION

Attach the original receipts and keep a copy for income tax purposes and coordination of benefits. The receipts will not be returned.

Name of patient	Date of birth	Relationship to member	For children over age 21, indicate whether a full-time student (you must include a full-time study certificate)	Amount
	Y Y Y Y M M D D		☐ Yes ☐ No	$
	Y Y Y Y M M D D		☐ Yes ☐ No	$
	Y Y Y Y M M D D		☐ Yes ☐ No	$
	Y Y Y Y M M D D		☐ Yes ☐ No	$

3. IN THE EVENT OF AN ACCIDENT ONLY

1. Was any care provided as the result of an accident? ☐ Yes → Date of the event: Y Y Y Y M M D D _____ ☐ No

2. Give a brief description of the circumstances of the accident (where and how):

4. COORDINATION OF BENEFITS

1. Are the attached receipts covered by: CNESST: ☐ Yes ☐ No SAAQ: ☐ Yes ☐ No

2. Are the attached receipts covered by another group insurance or individual insurance plan?

☐ Yes → Name of the insurance company: _____ ☐ No

5. AMBULANCE TRANSPORT

If your claim includes a receipt for ambulance services, please state the medical reason for the transportation.:

6. 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 the 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. ("iA Financial Group"), its employees, agents, reinsurers, service providers and other organizations working with iA Financial Group 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 iA Financial Group, 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, iA Financial Group 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 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 Y Y Y M M D D

7. IMPORTANT NOTICE

To ensure prompt and efficient payment, please take note of the following:

- Submit your invoices on a regular basis or within 90 days of the date the services were rendered.
- Include only official, original receipts **(these will not be returned)**. Duplicates and photocopies will not be accepted.
- The Primary Member must indicate all the information requested and sign the form.

EXPENSES INCURRED DURING THE YEAR MUST BE SENT TO THE INSURER WITHIN 90 DAYS FOLLOWING THE END OF THE CALENDAR YEAR, BEFORE MARCH 31ST OF EACH YEAR.

PLEASE SUBMIT FORM TO:

iA Financial Group Claims Department
1611 Crémazie Blvd. East, Suite 900
Montreal, QC H2M 2P2