If you have any questions or require any assistance with the completion of Claim Forms, please contact our office at: 1 800-266-5667 or email: specialmarkets-claims@ia.ca

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.
- Physician's Statement must be completed by a Licensed Medical Doctor (MD). Physician's Statement completed by a Physiotherapist or Chiropractor will not be accepted.
- 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 (EOB), 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.
- **For Sports Accident Policies:** The Team Authorization section must also be SIGNED & AUTHORIZED by one of the following officials: Manager / Coach / or Sports Team Authority ONLY. (Physiotherapists, Team Athletic Trainers/Therapists or any other service providers are not eligible to provide this authorization). The claim cannot be processed in the absence of this authorization.
- **For College/University Policies:** The Statement of College/University Authority section must also be SIGNED by an authorized person at the College/University. The claim cannot be processed in the absence of this authorization.
- Submit all forms together to the Company at the address below. You may also send your claim forms by fax. We wish to remind you that email is not a secure method of communication and should only be used to transmit non-confidential information.

!	**Claimant's Statement must be completed with all the Supporting Documents Required**

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

PLEASE RETURN ALL CLAIM FORMS AND SUPPORTING DOCUMENTATION TO OUR OFFICE BY MAIL OR FAX

Industrial Alliance Insurance and Financial Services Inc.
iA Special Markets (Claims Department)
400–988 Broadway West,
PO Box 5900, Vancouver, BC V6B 5H6

Tel 1-800-266-5667
Fax 1-866-913-3620

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Accident Reimbursement Plan

Claimant's Statement

! **To avoid any delays in processing of your claim, please send the duly completed claim form with all the supporting documents required.**

CLAIMANT (Applicant, Parent or Legal Guardian)

Policy Number: 100012610 | Member/Certificate ID (if any) | Last Name | First Name | Sex ❑ M ❑ F

Unit Number | Street Address | City | Province | Postal Code

Home Phone | Cell Phone | Email

School/College/Sports Team Name | School Board Name (if applicable)

IDENTITY OF THE INJURED PERSON

Last Name | First Name | Sex ❑ M ❑ F | Date of Birth (dd-mm-yyyy) | Provincial Health Card #

DESCRIPTION OF THE ACCIDENT AND RESULTING INJURIES

Date of Accident (dd-mm-yyyy) | 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

! **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

Please provide Name of Other Insurance Company (ies):

1. _____
2. _____

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

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

TEAM AUTHORIZATION

! **This section is to be signed by your designated Team Authority or Official (League Manager, Facility Manager etc.)**

Name of Team | Rink Name | What Sport is the Team engaged in?

Name of League or Association | On what date did the player join team? (dd-mm-yyyy)

Was the above Player a regular member at the time of injury? ❑ Yes ❑ No

Was the Player injured during an approved activity? ❑ Yes ❑ No If Yes, an approved ❑ Practice ❑ Game ❑ Traveling

Was the Player wearing a visor at the time of the accident? ❑ Yes ❑ No

Signature of Person Authorized by Policyholder | Print Name | Official Capacity/Title

Complete Address / Phone number | Email | Date Signed

STATEMENT OF COLLEGE/UNIVERSITY AUTHORITY

Name of Student | Policy No. | Reg. No. | Name of Group

On the date of the accident, we certify that the above claimant was enrolled as a: ❑ Full Time Student (3 or more courses) ❑ Part Time Student ❑ International Student

Name of Authorized Person | Signature | Email | Phone Number | Date Signed

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.**

I declare that the information provided in the Claimant's Statement is accurate and any statements provided in any personal or telephone interview concerning this claim will be true and complete. I agree that all such statements form the basis for any benefit approved as the result of this claim.

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Accident Reimbursement Plan

Physician's Statement

! TO BE COMPLETED BY A MEDICAL DOCTOR (M.D.) THE CLAIMANT IS RESPONSIBLE FOR ANY FEE FOR THE COMPLETION OF THIS FORM FOR MEDICAL EXPENSES, DISMEMBERMENT OR TOTAL AND PERMANENT LOSS OF USE.

Date of Accident (dd-mm-yyyy)

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

Nature of Injury

❑ Fracture Location and Type

❑ Other Injury Location and Type

Visual Injury ❑ Yes ❑ No If "Yes", please provide details.

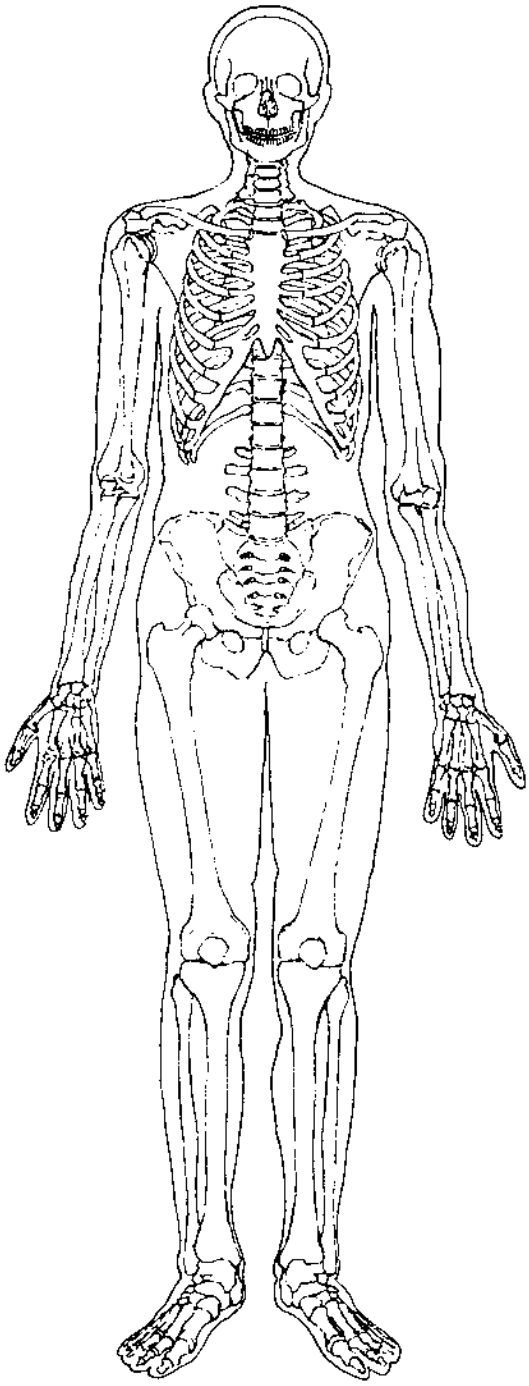
Was surgery required? ❑ Yes ❑ No

Surgery Date (dd-mm-yyyy)

General Anesthetic ❑ Yes ❑ No

Has the patient been referred for any Paramedical treatment? ❑ Yes ❑ No

If yes, please describe:



! Please complete the following 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?

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 (dd-mm-yyyy)

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

Physician Name (Please print)

Telephone

Address

Physician Name (Please print)

Telephone

Address

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

Physician Name (Please print)

Address

Telephone

Signature

Date Signed (dd-mm-yyyy)

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Accident Reimbursement Plan

Dentist's Statement – Dental Care

! THIS SECTION IS TO BE COMPLETED BY THE DENTIST. PLEASE ALSO ATTACH THE STANDARD DENTAL CLAIM FORM FOR DENTAL SERVICES PROVIDED.

PATIENT/CLAIMANT INFORMATION

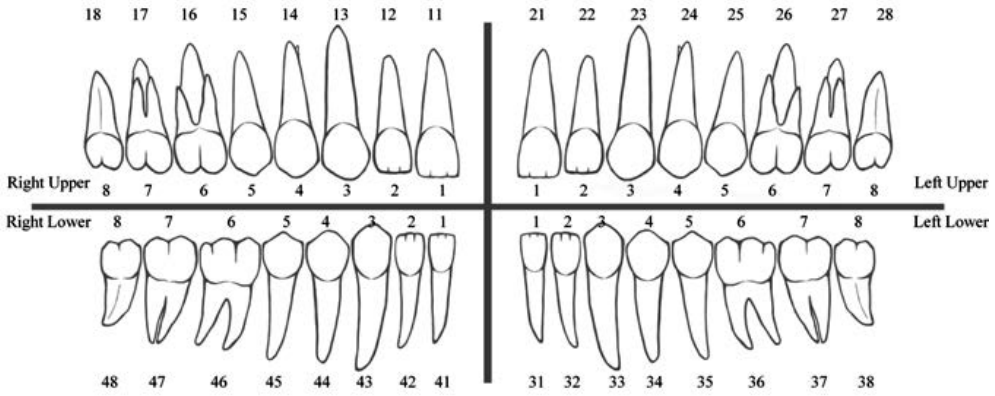
Name | Address

City | Province | Postal Code | Home Phone | Cell Phone

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

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):

Is the member covered by another insurance plan (employer or other insurance) ❑ Yes ❑ No
If yes, Please provide the name of the Other Insurance company and Provide EOB

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

Describe further potential problems and indicate the time frame:

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.

I hereby assign benefits payable from this claim to the below named dentist and authorize payment directly to the dentist.

Signature of subscriber

I understand that the fees in this claim may not be covered by or may exceed my policy benefits. I understand that I am financially responsible to my dentist for the entire cost of the treatment. I authorize the release of the information contained in this claim of services described in this form to the named dentist.

Signature of the Patient (or Parent/Legal Guardian)

NAME AND ADDRESS OF DENTIST

Dentist Name (Please print) | Address | Telephone

Signature | Date Signed (dd-mm-yyyy)

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Authorization Form

PRIVACY STATEMENT

At Industrial Alliance Insurance and Financial Services Inc., ("the Company") we recognize and respect every individual's right to privacy. Personal information about you is kept in a confidential claim file at the offices of the Company or of an organization authorized by the Company in a secure area. We limit access to information in your files to The Company staff or persons authorized by the Company who require this access to perform their duties, to persons to whom you have granted access, and to persons authorized by law. We use this information to investigate, assess and administer your claim and the terms of the Insurance contract provisions. You may access the personal information contained in your file and correct any inaccurate information. Any personal health information will be provided to you through a medical practitioner of your choice. To view your personal information please send a request in writing to the attention of the Claims Department at the above address, together with the name of the Medical practitioner.

AUTHORIZATION AND DECLARATION

I hereby authorize Industrial Alliance Insurance and Financial Services Inc., ("the Company") for the purposes of investigation, evaluation and administration of my claim:

a) to gather only the information necessary for the above specified purposes from any person or organization that has personal information relating to me, including other insurers, reinsurers, and financial institutions; physicians, medical institutions and healthcare providers; employers or administrators of group benefits; agents or brokers; investigating and credit reporting agencies, and all persons or organizations likely to have personal information relevant to my claim.

b) to disclose and exchange only the necessary personal information the Company has relating to me to the above persons and organizations.

I understand that the personal information obtained using this authorization will be used by the Company in the investigation, administration and evaluation of a claim for benefits. Any information obtained will not be released by the Company, except to persons or organizations performing business or legal services in connection with my claim, or as may be otherwise lawfully required or as I may further authorize.

I confirm that a photocopy or electronic copy of this authorization shall be valid as the original.

I declare that the information provided in the Claim Form is accurate and any statements provided in any personal or telephone interview concerning this claim will be true and complete. I agree that all such statements form the basis for any benefit approved as the result of this claim.

Claimant's Name (Please Print) _____

Signature of Claimant or Parent or Legal Guardian (if minor) _____ Date Signed (yyyy-mm-dd) _____