

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

**CLAIM FORM**  
**MEDICAL EXPENSES**  
 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:

Telephone \_\_\_\_\_  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 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, 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		Full-time student			Name of school
No	Yes	No	Yes		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	\$ _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	\$ _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	\$ _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	\$ _____

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, its employees, agents, reinsurers, service providers and other organizations working with Industrial Alliance 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 Industrial Alliance, 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, 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 AGREE** that a photocopy of this Confirmation/Authorization shall be as valid as the original.

Member's signature **X** \_\_\_\_\_ Date 

Y	M	D

 F54-326A(12-12)

## INDUSTRIAL ALLIANCE 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 Forms	<ul style="list-style-type: none"> <li>• Other claim forms, including HSA forms, questionnaires and more information can be found on our website at <a href="http://www.inalco.com">www.inalco.com</a>.</li> </ul>
Coordination of Benefits	<ul style="list-style-type: none"> <li>• This establishes the order in which two or more insurance companies will pay benefits for the same claim (maximum 100%).</li> <li>• For detailed instructions and scenarios regarding coordination of benefits, please refer to the "Coordination of Benefits Guide available" on our website.</li> </ul>
Claims related to a work or motor vehicle accident	<ul style="list-style-type: none"> <li>• If your claim is related to a work accident, submit the initial claim to your provincial Workers' Compensation Board if applicable.</li> <li>• If your claim is related to a motor vehicle accident, submit the initial claim to your motor vehicle insurance, if applicable.</li> </ul>
Expenses incurred outside of Canada	<ul style="list-style-type: none"> <li>• Expenses incurred outside of Canada are handled by CanAssistance. For inquiries or questions, contact CanAssistance at <b>1 800 203 9024</b>. The travel insurance claim forms from CanAssistance, specific to your province of residence, can be found on the Industrial Alliance website.</li> </ul>

### CLAIM REQUIREMENTS

Original detailed receipts should include the following:	<ul style="list-style-type: none"> <li>• Claimant's full name</li> <li>• Date, cost and type of treatment</li> <li>• Supplier or Provider's name and credentials</li> </ul>
Paramedical Services (e.g. massage therapy, physiotherapy, chiropractic, etc.)	<ul style="list-style-type: none"> <li>• Original detailed receipt including medical referral if required by your group policy</li> </ul>
Foot Orthotics	<ul style="list-style-type: none"> <li>• Original detailed receipt</li> <li>• Casting technique</li> <li>• Credentials of qualified health practitioner who performed the casting (Chiropodist, Chiropractor, Orthotist, Podiatrist, Physiotherapist or Podiatrist)</li> </ul>
Orthopedic Shoes	<ul style="list-style-type: none"> <li>• Original detailed receipt</li> <li>• Medical referral from a medical doctor, podiatrist, chiropodist, physiotherapist or chiropractor</li> </ul>
Hospital Beds & Wheelchairs	<ul style="list-style-type: none"> <li>• Original detailed receipt including breakdown of charges</li> <li>• Medical referral with diagnosis and symptoms</li> <li>• Expected length of time required</li> <li>• Purchase date of previous appliance, if applicable</li> </ul>
Orthopedic Appliances (e.g. knee & back braces)	<ul style="list-style-type: none"> <li>• Original detailed receipt specifying the type of appliance</li> <li>• Medical referral with diagnosis and symptoms</li> <li>• Expected length of time required</li> </ul>
Nursing Care	<ul style="list-style-type: none"> <li>• The nursing care benefit requires pre-approval from Industrial Alliance. Download and complete the questionnaire and submit it to Industrial Alliance. You can find the questionnaire in our website.</li> </ul>

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

[www.inalco.com](http://www.inalco.com)