iA Financial Group

CLAIM FORM
DENTAL CARE IN CASE OF AN ACCIDENT

GROUP INSURANCE

Depending on 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

PART 1: DENTIST'S STATEMENT

Patient (Last and first name)

_____

For dentist's use only to provide additional information, diagnosis, procedures, or special considerations:

Duplicate ☐ Predetermination ☐

Dentist (Last and first name/Address/Phone no.)

_____

_____

_____

I hereby assign my benefits payable from this claim to the specified dentist and authorize payment directly to him/her.

_____

Signature of subscriber

I understand that I am responsible for the fees incurred independent of the claim and the coverage I have. I acknowledge that the total fee of $_____ is accurate and has been charged to me for services rendered.

Member's signature _____

Verification (Dentist) _____

Treatment and services rendered to the patient

DATE OF SERVICE Y	M	D	PROCEDURE CODE	INT. TOOTH CODE	TOOTH SURFACES	DENTIST'S FEES	LABORATORY CHARGES	TOTAL CHARGES

Total fee submitted _____

NOTE - PLEASE INCLUDE THE X-RAYS TAKEN BEFORE THE TREATMENT

1. Tooth code of teeth damaged as a result of the accident: _____

2. Condition of teeth prior to the accident. (Were they sound natural teeth?) Give details: _____

_____

_____

_____

3. If treatment cannot be given immediately, specify the dates and nature of future treatment(s), as well as the reason for the delay: _____

_____

_____

_____

4. Additional information: _____

I hereby certify that the foregoing statements accurately describe the treatment given and fees incurred, and that the said treatment was necessary as the result of an accident.

Dentist's signature _____ Date Y M D _____

PLEASE COMPLETE AND SIGN THE REVERSE SIDE OF THIS FORM.

PART 2: MEMBER'S STATEMENT

COORDINATION OF BENEFITS

IMPORTANT NOTE:

- *If one of your dependents is covered under another plan for medical expense benefit, the expenses incurred by this dependent must first be submitted to the other insurer. You may subsequently submit a claim for the balance, if applicable, under your plan.*
- *The expenses incurred by dependent children must be submitted to the plan of the parent whose birthday comes first during a calendar year.*

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

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1. Expenses incurred by _____ Date of birth Y M D Relationship _____

2. Date accident occurred Y M D

3. Place accident occurred: _____

4. Circumstances of the accident: _____

MEMBER CONFIRMATION/AUTHORIZATION

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

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 Insurance and Financial Services Inc. (the "Company"), 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, private or public organization or institution to disclose to the Company, its employees, agents and service providers any information regarding the treatment 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, the Company 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 _____

Home phone _____ Work phone _____ Ext. _____