

**Quebec**  
 Group Health and Dental Claims  
 PO Box 800, Station Maison de la Poste  
 Montreal, Quebec H3B 3K6

**All Other Provinces**  
 Group Health and Dental Claims  
 PO Box 4643, Station A  
 Toronto, Ontario M5W 5E3

**INSTRUCTIONS**

- The details requested below are required in order for Industrial Alliance Insurance and Financial Services Inc. (the “Company”) to determine the eligibility of your request for reimbursement under the home care benefit. For prior approval, please forward this form to the address indicated above. You will then receive a confirmation letter from the Company concerning your request once the review has been completed.
- In order to determine the eligibility of your request for reimbursement under the home care benefit, please have the patient's attending physician provide the information requested in the "TO BE COMPLETED BY THE ATTENDING PHYSICIAN" section which is on the reverse side of this form.
- Some financial assistance programs are available for home care services. You must register for these programs, based on your territory, if the care is needed for more than two weeks.

**Quebec residents:**  
 · Integrated Health and Social Services Centres (CISSS)  
 · Local Community Services Centres (CLSC)

**Other provinces residents:**  
 · Community Care Access Centre (CCAC)  
 · Local Health Integration Networks (LHIN)

**TO BE COMPLETED BY THE PLAN MEMBER (PLEASE PRINT CLEARLY)**

**1. PLAN MEMBER INFORMATION**

Policy no. [ ] Certificate no. [ ]  
 Plan member's name \_\_\_\_\_  
 Patient's name \_\_\_\_\_ Date of birth [ ] Y [ ] M [ ] D [ ]  
 Relationship to the plan member \_\_\_\_\_

**2. COORDINATION OF BENEFITS**

Are these fees covered by another insurance plan?  No  Yes  
 If yes, please provide the name of the policyholder \_\_\_\_\_  
 Name of the other insurance company \_\_\_\_\_ Contract no. \_\_\_\_\_  
 Protection:  Family  Single parent  Individual  Couple

**3. NATURE OF FEES**

Are the fees to be incurred for home care services related to:  
 A work accident?  Yes  No  
 A car accident?  Yes  No  
 Other, specify: \_\_\_\_\_  
 Date of accident: [ ] A [ ] M [ ] J [ ]

**4. TRANSPORTATION FEES**

During your recovery at home, will you need to travel to receive medical care or medical follow-up?  No  Yes  
 Which doctor(s) will you need to consult? \_\_\_\_\_  
 \_\_\_\_\_

Indicate the dates of the consultations

[ ] Y [ ] M [ ] D [ ]	[ ] Y [ ] M [ ] D [ ]	[ ] Y [ ] M [ ] D [ ]	[ ] Y [ ] M [ ] D [ ]	[ ] Y [ ] M [ ] D [ ]
[ ] Y [ ] M [ ] D [ ]	[ ] Y [ ] M [ ] D [ ]	[ ] Y [ ] M [ ] D [ ]	[ ] Y [ ] M [ ] D [ ]	[ ] Y [ ] M [ ] D [ ]

**Note: Please provide a medical certificate from your doctor for each consultation and indicate the dates of the hospitalization period or the date of the day surgery. Fees are only reimbursed upon presentation of receipts (e.g., gasoline, bus, parking).**

**5. CHILD CARE FEES**

During your recovery, will you incur child care fees that are in excess of those usually incurred?  No  Yes  
**Note: Please provide receipts clearly indicating the name of the child care service provider, including the address and telephone number.**

**6. PLAN MEMBER CONFIRMATION / AUTHORIZATION**

If this questionnaire is being submitted in respect of my spouse or dependent child, I CONFIRM that I am AUTHORIZED to disclose information about him/her in regards to the home care services to be or being received.  
 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 Insurance and Financial Services Inc., its employees, agents and any service providers any information which they may need in the assessment of the information contained in this questionnaire in order to determine the eligibility for the home care benefit.  
 I AUTHORIZE the use of my Social Insurance Number as an identification number where required for administration of the group policy.  
 I AGREE that a photocopy of this Confirmation/Authorization shall be as valid as the original.

Patient's name \_\_\_\_\_ Date signed [ ] Y [ ] M [ ] D [ ]

**Please have the attending physician complete and sign the reverse side of this form.**

7. PATIENT CLINICAL INFORMATION

Please answer all the following questions

Was the patient hospitalized?  No  Yes

If yes, specify date of admission [ ][ ] Y [ ][ ] M [ ][ ] D and date of discharge [ ][ ] Y [ ][ ] M [ ][ ] D

Did the patient undergo day surgery?  No  Yes If yes, specify the date of surgery [ ][ ] Y [ ][ ] M [ ][ ] D

Did the patient receive care/treatment in the emergency room?  No  Yes If yes, date of consultation at the emergency room [ ][ ] Y [ ][ ] M [ ][ ] D

Length of stay under observation at the emergency room (number of hours) \_\_\_\_\_

The specific medical reasons that required hospitalization, surgery or one-day consultation at the emergency room \_\_\_\_\_

\_\_\_\_\_

Please specify the nature of the surgery \_\_\_\_\_

\_\_\_\_\_

What other health problem(s) does the patient have? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Description of care required \_\_\_\_\_

\_\_\_\_\_

Name of home care service provider \_\_\_\_\_

Is he/she an immediate family member (spouse, mother, father, child, brother or sister of the insured)?  No  Yes

Address \_\_\_\_\_ Phone number [ ][ ][ ][ ] [ ][ ][ ][ ] [ ][ ][ ][ ] [ ][ ][ ][ ]

Period during which home care is required [ ][ ][ ][ ] hours / [ ][ ][ ][ ] days until [ ][ ] Y [ ][ ] M [ ][ ] D

Description of services  Hygiene  Mobilization  Weekly housekeeping

Food  Other \_\_\_\_\_

Is the patient in the terminal phase of an illness?  No  Yes

7. PATIENT CLINICAL INFORMATION

I hereby confirm that the above information is true and complete to the best of my knowledge.

Physician's name \_\_\_\_\_ Telephone [ ][ ][ ][ ] [ ][ ][ ][ ] [ ][ ][ ][ ] [ ][ ][ ][ ]

Address \_\_\_\_\_ Fax [ ][ ][ ][ ] [ ][ ][ ][ ] [ ][ ][ ][ ] [ ][ ][ ][ ]

General practitioner  Specialist  Other  Specify \_\_\_\_\_

Signature \_\_\_\_\_ Date signed [ ][ ] Y [ ][ ] M [ ][ ] D