INDUSTRIAL ALLIANCE
INSURANCE AND FINANCIAL SERVICES INC.

www.inalco.com

GROUP INSURANCE

CLAIM FORM

DENTAL CARE IN CASE OF AN ACCIDENT

According to your region, please submit the completed form to:

Quebec
PO Box 800, Station Maison de la Poste
Montreal, Quebec H3B 3K5

Ontario, Atlantic and Western Provinces
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	Internal 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. Code number of teeth damaged as a result of the accident: _____

2. Condition of teeth prior to the accident. (Were they sound and whole?) 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 a result of an accident.

Dentist's signature _____ Date _____

PLEASE COMPLETE AND SIGN THE REVERSE SIDE OF THIS FORM.

PART 2: MEMBER'S STATEMENT

COORDINATION OF BENEFITS

IMPORTANT NOTE:

Under the coordination of benefits section of your plan, if your spouse is covered under a medical expense benefit, the expenses incurred by your spouse must first be submitted to his/her insurer. You may subsequently submit a claim for the balance, if applicable, under your plan.

The expenses incurred by insured dependent children must be submitted to the plan of the parent whose birthday comes first during a calendar year.

Is your spouse, if applicable, covered by another group plan? ❑ No ❑ Yes Specify:

Name of insurance company _____ Policy no. _____ Coverage: ❑ Individual ❑ Family

Name of spouse _____ 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, 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 Industrial Alliance, its employees, agents and service providers any information regarding the treatment charges incurred which they may need in the assessment of the claim.

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 _____

Address _____ Postal code

Tel. home Tel. work

DISCLOSURE

At Industrial Alliance, the personal information we collect concerning you and your insured dependents is kept in strict confidence and is only used for the purposes you have authorized. Your personal file will be kept at Industrial Alliance's offices.

You have the right to request access to your personal information and, if necessary, correct any inaccurate information. In order to do so, send a written request to the following address: Industrial Alliance Insurance and Financial Services Inc., Access Officer, 1080 Grande Allée West, PO Box 1907, Station Terminus, Quebec City, Quebec G1K 7M3

Access to your personal information will be limited to Industrial Alliance's employees, agents, reinsurers and service providers in the performance of their jobs, individuals to whom you have granted access, and persons authorized by law.

For the purposes of audits and administrative reporting, Industrial Alliance may release to your Employer/Policyholder statistical financial information without personal identifiers.

Industrial Alliance may establish a list of its insureds to share information within the Industrial Alliance Group. This will help us serve them better and determine whether any products and services that the Industrial Alliance Group offers are suitable so we can offer such products and services to them. However, you are entitled to have your name removed from this list by making a written request to this effect to the Access Officer, as referred to above.