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According to your region, please submit 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

**CLAIM FORM  
MEDICAL EXPENSES**

Policy no.  Policyholder's name

Member's last name  First name

Certificate no.  Date of birth  Sex:  M  F Language:  E  F

**COORDINATION OF BENEFITS**

Are you or your dependent(s) covered by another group plan?  No  Yes Specify:

Name of insurance company  Policy no.  Coverage:  Individual  Family

Name of spouse  Date of birth

**MEDICAL EXPENSES**

*(Attach the original receipts and keep a copy for income tax purposes and the coordination of benefits. If there are three originals, please enclose Original 1.) The receipts will not be returned and they will be destroyed 60 days after receipt.*

NAME (member or insured dependent)	RELATIONSHIP TO THE MEMBER	DATE OF BIRTH Y M D	Handicapped child		Full-time student		Name of school	TOTAL
			No	Yes	No	Yes		
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	\$ <input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	\$ <input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	\$ <input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	\$ <input type="text"/>

If there are expenses for the rental or purchase of an appliance, please attach a letter from your physician describing the diagnosis.

Expenses following an accident?  No  Yes Nature of accident:  Work  Motor vehicle  Crime victim  Other

Date of accident  Place of accident

**AMBULANCE TRANSPORTATION FEES (Enclose the receipt from the ambulance service)**

Reason for ambulance service

Place of pick-up:  Home  Work  Other Specify:

**EXPENSES INCURRED OUTSIDE THE PROVINCE OF RESIDENCE**

If the medical expenses were incurred outside the province of residence, please complete F54-371A - MEDICAL EXPENSES INCURRED OUTSIDE THE PROVINCE OF RESIDENCE. To obtain a copy of this form, please call 514 499-3747 or 1 800 203-9024 if you are calling from outside the Montreal area.

**MEMBER CONFIRMATION/AUTHORIZATION**

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

**I HEREBY CONFIRM** that the expenses were incurred by myself or by one of my insured dependents and are required in connection with the treatment of a medical condition.

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, public or private organization or institution to disclose to Industrial Alliance, its employees, agents and service providers any information regarding the treatment and 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  Extension