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 _____ Gender: ☐ 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:

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) _____

Duplicate ☐ Predetermination ☐

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 fees submitted _____

NOTE: PLEASE ATTACH THE MOST RECENT X-RAYS TAKEN BEFORE THE ACCIDENT AND THOSE TAKEN AFTER THE ACCIDENT PRIOR TO RECEIVING ANY 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?) Provide 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

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: _____

_____

_____

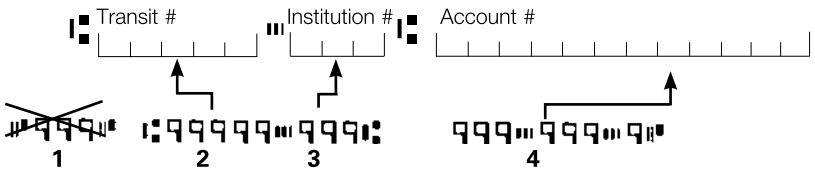
_____

PART 3: DIRECT DEPOSIT AND NOTIFICATION

Direct deposit of your health and/or dental claim reimbursements and notification of claim processing

Complete only when signing up for direct deposit or to update your information.

Banking information for direct deposit:



1. Cheque number (do not write this number).
2. Transit number (5 digits).
3. Financial institution number (3 digits).
4. Account number up to 12 digits. The format may vary from one financial institution to another.
   Indicate all numbers and only the numbers.

Email address for notification: _____ ☐ Personal ☐ Work

⚠ **To receive notifications, you must provide your email address and your banking information.**

☐ I do not want to receive notification

You can view the status and details of your health and/or dental claims via My Client Space (ia.ca/myaccount), our secure website, at any time.

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 **AUTHORIZE**D to disclose information about them with respect to this claim.

I AUTHORIZE Industrial Alliance Insurance and Financial Services Inc. ("iA Financial Group") to deposit in my bank account, using the banking information I have provided above, any amounts payable in regards to a health and/or dental claim that I submit under my group insurance plan.

I AGREE that this authorization will apply until such time as I submit a written request to the contrary to iA Financial Group.

I UNDERSTAND that iA Financial Group will have no further obligation with regard to the claims paid.

I ALSO UNDERSTAND that iA Financial Group can, without prior notice, terminate the direct deposit of my claims payments. This authorization takes effect on the date indicated below and will be valid for all other active bank accounts at this or any other financial institution that I may name in the future.

Furthermore, **I UNDERSTAND** and **AGREE** that if I provide iA Financial Group with incorrect banking information or if I fail to notify iA Financial Group of any change in my banking information and, as a result of this error or omission, the amount of a paid claim is deposited into the wrong bank account, iA Financial Group cannot be held responsible or liable for this error or omission or be obligated to reimburse me if iA Financial Group is unable to recover the amount that was paid into the wrong account.

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. ("iA Financial Group"), 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 iA Financial Group, 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, iA Financial Group 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.