iA Financial Group

WELLNESS ACCOUNT claim form

GROUP INSURANCE

According to your region, please submit complete form to:

Quebec

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

All Other Provinces

PO Box 4643, Station A
Toronto, Ontario M5W 5E3

1. MEMBER INFORMATION

Policyholder's name _____ Policy no. _____

Member's last name _____ First name _____

Certificate no. _____ Date of birth Y M D Gender: ☐ M ☐ F Language: ☐ E ☐ F

2. EXPENSES TO BE REIMBURSED

Please attach original receipts for all expenses to be reimbursed. Keep a copy of all receipts as they will not be returned.

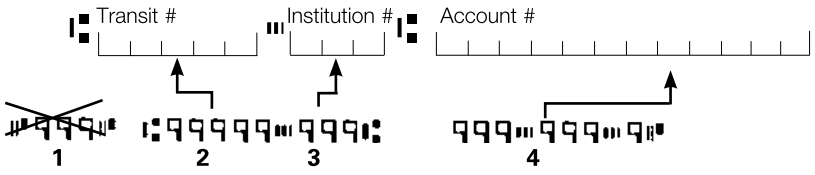
DESCRIPTION OF EXPENSE	AMOUNTS TO BE REIMBURSED FOR EACH EXPENSE ($)
TOTAL	

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.

4. MEMBER CONFIRMATION/AUTHORIZATION

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

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 **AGRE**E 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.

I RELEASE 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.

I AUTHORIZE any healthcare provider or professional, medical organization, insurance or reinsurance company, workers' compensation board, the policyholder, my employer, and any other person, private or public organization or institution to disclose to the Company, its employees, agents, reinsurers and service providers any information regarding the expenses which they may need in the assessment of the claim.

I AUTHORIZE the Company to release to my employer/policyholder the amount of my account balance under the wellness account when required for the provision/management of the wellness account.

I AUTHORIZE the use of my Social Insurance Number as an identification number when it is required for the administration of the wellness account.

I AGREE that a photocopy of this Confirmation/Authorization shall be as valid as the original.

Member's signature X _____ **Date** _____

Address _____ **Postal code** _____