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ACCIFAMILY/ACCIGROUP/ACCIGROUP PLUS ACCIDENT INSURANCE - CLAIMANT'S STATEMENT



Accident Insurance (IRW2563) 1080 Grande Allée West PO Box 1907, Station Terminus Quebec City, QC G1K 7M3	Telephone Quebec City region: 418-684-5405 Elsewhere: 1-888-266-2224		For rapid processing of your request, please send the duly completed form. It will be returned to you if any information is missing.
INSTRUCTIONS: The claimant's statement	, original invoices and other proof must be	Step ⁻	CLAIMANT (applicant, father, mother or guardian)
submitted within 90 days following the date of the accident. Follow the steps below, sign the request and the authorization and send the documents to the address above. In all cases involving death, dismemberment or loss of use and disability, contact your agent or the Company at the phone number indicated above.			act:ant's name:
	rate or government organization such as the t submit your claim to this organization and as of the invoices.	Addre	SS:
Limitation period (mandatory statement fo only): Every action or proceeding against a money payable under your contract is abs the time set out in the <i>Insurance Act</i> .	an Insurer for the recovery of insurance	Telepl Cell:	City Province Postal code none:
Step 2 IDENTITY OF THE INJU	JRED PERSON		
			Date of birth: Y M D Sex: M F School board:
Step 3 DESCRIPTION OF THE	ACCIDENT AND RESULTING INJ	URIES	
	ace, injury) (Add a dated and signed sh	eet if ne	eded)
	-		or sports association
Step 4 DENTAL CARE (To be c			
	Dentist's standard dental care form		
	e were caused by an accident that too oth:		e on:
	accident (i.e., if the tooth was whole		
	ccident. Specify:		Member:
Dentist's signature		Т	elephone:
			e required forms completed at their own expense.)
Check the following page to find ou	it which documents are required. Ens	ure that	the benefit and/or guarantee claimed is covered in your contract.
Step 6 DECLARATION AND A		_	
Are you covered by another insurar	ce plan (employer or other insurance)	? ∐ Y	es 🗋 No
You must first submit your claim to this insure send us a copy of the settlement and attach a of the invoice.	conv		Contract No.: Certificate No.:
I hereby certify that the information pre- exclusive benefit of the above-mention private organization that has persona Inc. or its authorized representative. A	ned person. To evaluate my claim, I au I information about me or my family to photocopy of this authorization shall be	nowledge thorize a provide as valid	•
Date: Cla	imant's signature:		

DOCUMENTS REQUIS

Fracture	
- skull fracture with depressed skull	Copy of written radiology report OR written confirmation from orthopedic surgeon
- spinal fracture with displaced vertebrae	Copy of written radiology report OR written confirmation from orthopedic surgeon
- pelvic fracture	Copy of written radiology report OR written confirmation from orthopedic surgeon
- fracture of a bone not listed above	Written confirmation of physician or orthopedist
Child care expenses	Receipt showing the number of hours, the hourly rate and the name of the adult caregiver who is not a family member
Room and board for the person assisting the insured if the latter is hospitalized more than 50 miles from home	Confirmation of hospitalization indicating the admission and discharge date
Convalescence allowance (18 years of age and over)	1
Each night spent in hospital	Confirmation of hospitalization indicating the admission and discharge date
For a day surgery	Written confirmation of the surgeon or physician, with diagnosis
Hospitalization allowance	Confirmation of hospitalization indicating the admission and discharge date
Transportation expenses (between home and educational institution)	Transportation details (date, place of departure, place of arrival, number of kilometres traveled)
Тахі	Original receipt

Coordination of benefits for dental, hospital, paramedical and emergency care expenses: You must always submit claims for reimbursement to other plans first (public, private or group insurance plans). Once you receive a copy of these other insurance benefit statements, please send them to us to complete your claim.

Orthopedic devices	- Original invoices for rental
	- Copy of the medical recommendation
Hospital room (private or semi-private)	Original invoice
Wheelchair, crutches or orthopedic devices	- Medical recommendation indicating the rental duration
	- Original invoice at the end of the rental
	- If it is more expensive or impossible to rent, first submit purchase estimate to us
Dental expenses	X-rays Standard dentist claim form (original)
Damaged glasses or contact lenses	Original invoice for the repair or replacement
Therapeutic medication	- Invoice showing the name of the therapeutic medication
	- Proof of payment from other insurer (public, private or group insurance plan
Treatment by a physiotherapist, chiropractor, occupational therapist, podiatrist, osteopath, audiologist, speech therapist	- Original receipts stating the reason for treatment, date and cost of each visit
Fibreglass cast (initial)	Original receipts stating the reason for treatment, date and cost of each visit
Prosthetic devices	- Original invoice
	- Surgeon's recommendation
Out-of-hospital nursing services	- Itemized invoice (dates, number of hours, copy of license)
	- Medical recommendation
Emergency transportation (ambulance)	Original invoice specifying place of departure and arrival

For the following claim types, please contact us at 1-888-266-2224 Death Disability Dismemberment or loss of use Please note that this list is not exhaustive and other documents may be required to complete your claim.