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

iA Financial Group

ACCIDENT INSURANCE

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 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.

Certain accidents may be covered by a private or government organization such as the WCB, SAAQ, RAMQ or IVAC. You must first submit your claim to this organization and send us a copy of the settlement with copies of the invoices.

Limitation period (mandatory statement for Alberta and British Columbia residents only): Every action or proceeding against an Insurer for the recovery of insurance money payable under your contract is absolutely barred unless commenced within the time set out in the *Insurance Act*.

Step 1 CLAIMANT (applicant, father, mother or guardian)

Contract: ______________________

Claimant's name: ______________________

Address: ______________________
Street

______________________ ☐☐ ☐☐☐☐☐☐
City Province Postal code

Telephone: ☐☐☐ ☐☐☐ – ☐☐☐☐

Cell: ☐☐☐ ☐☐☐ – ☐☐☐☐

Step 2 IDENTITY OF THE INJURED PERSON

Name: ______________________ Date of birth: Y ☐☐☐☐ M ☐☐ D ☐☐ Sex: ☐ M ☐ F

School attended: ______________________ School board: ______________________

Step 3 DESCRIPTION OF THE ACCIDENT AND RESULTING INJURIES

Date: Y ☐☐☐☐ M ☐☐ D ☐☐ Time: ________ ☐ a.m. ☐ p.m.

How did the accident occur? **(place, injury) (Add a dated and signed sheet if needed)**

____

____

For Accigroup only: signature of the authorized person from the school, group or sports association ______________________

Transportation: Indicate the number of kilometres travelled within 24 hours after the accident. ______________________

Step 4 DENTAL CARE (To be completed by the dentist)

Documents required: • X-rays • Dentist's standard dental care form

Dentist's statement

The injuries described above were caused by an accident that took place on: Y ☐☐☐☐ M ☐☐ D ☐☐ Date of the first visit: Y ☐☐☐☐ M ☐☐ D ☐☐

Identification of damaged tooth: ______________________

Nature of the injury: ______________________

State of tooth • before the accident (i.e., if the tooth was whole and sound) Specify: ______________________

• after the accident. Specify: ______________________

Dentist's name: ______________________ Member: ______________________

Address ______________________

Dentist's signature ______________________ Telephone: ☐☐☐ ☐☐☐ – ☐☐☐☐ Date: A ☐☐☐☐ M ☐☐ J ☐☐

Step 5 DOCUMENTS REQUIRED (The claimant is responsible for having the required forms completed at their own expense.)

Check the following page to find out which documents are required. Ensure that the benefit and/or guarantee claimed is covered in your contract.

Step 6 DECLARATION AND AUTHORIZATION

Are you covered by another insurance plan (employer or other insurance)? ☐ Yes ☐ No

You must first submit your claim to this insurer then send us a copy of the settlement and attach a copy of the invoice.

Company: ______________________ Contract No.: ______________________

Name of insured: ______________________ Certificate No.: ______________________

Are the benefits under this claim covered by this insurance? ☐ Yes ☐ No

I hereby certify that the information provided herein is true to the best of my knowledge and that all expenses were incurred by me (or my dependents) for the exclusive benefit of the above-mentioned person.

Authorization relating to the protection of personal information

I authorize iA Financial Group, its affiliates and its reinsurers to collect from any health care professional, public or private health or social services facility, the Régie de l'assurance maladie du Québec, any insurance company, financial institution, employer, former employer, MIB LLC, private investigator, group insurance administrator or private or public organization which holds personal or medical information about me, or to disclose information about me to them including my health status, medical history and any other information relevant for processing requests related to my claims. The personal information that we, iA Financial Group and our affiliates collect in connection with your request will be used and disclosed only for the purposes for which you have already consented. To review your consent preferences or to learn more, please consult our Privacy Notice at https://ia.ca/privacy-policy.

A photocopy of this authorization shall be as valid as the original.

Date: ______________ Claimant'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)	
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)
Taxi	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.