iA Financial Group

ACCIDENTAL DISMEMBERMENT CLAIM FORM

GROUP INSURANCE

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

PART A - EMPLOYER'S STATEMENT

Policy no. _____ Certificate no. _____ Effective date of the certificate Y M D

Name of the member _____ Date of birth Y M D

Occupation _____ Annual salary $ _____

Amount of the accidental dismemberment benefit $ _____ Amount of group life insurance $ _____ Amount of claim $ _____

Employment with us began on Y M D Date last reported to work Y M D

Afterwards, did not report for work because of: _____

Name of authorized person _____ Telephone

Signature _____ Date Y M D

PART B - MEMBER'S STATEMENT

Claim is for: ❒ myself ❒ my dependent – please specify name _____

Relationship to member _____ Date of birth Y M D

Date of accident Y M D Time of accident: _____

Place accident occurred: _____

Give a brief description of the accident (attach a copy of the accident report, if any): _____

Date injury first treated? Y M D Where injury first treated? _____

Give the name of the hospital where you or your dependent stayed: _____

Hospitalization period: _____

Names and addresses of physicians who have treated you or your dependent since the accident occurred: _____

Have you or your dependent applied for benefits under:

❒ workers' compensation legislation ❒ provincial automobile insurance legislation ❒ other – please specify _____

Please provide any information which might assist Industrial Alliance Insurance and Financial Services Inc. in processing this claim:

MEMBER CONFIRMATION AND 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 or dependent child, I confirm that I am **AUTHORIZED** to disclose information about him or her with respect to this claim.

On behalf of myself, **I HEREBY 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 Industrial Alliance Insurance and Financial Services Inc. (the "Company"), its employees, its reinsurers, agents and service providers or to any agency acting on behalf of the Company, any health information, records or knowledge about myself which they may need in the assessment of this claim.

If this claim is being made on behalf of my spouse or dependent child, **I HEREBY 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 the Company, its employees, its reinsurers, agents and service providers or to any agency acting on behalf of the Company, any health information, records or knowledge about my spouse or dependent child which they may need in the assessment of this claim.

On behalf of myself, **I CONSENT TO THE RELEASE** of the information contained in this form to my Employer/Policyholder and the Company, its employees, agents, reinsurers and service providers for the purposes of underwriting, administration and the processing of this claim.

If this claim is being made on behalf of my spouse or dependent child, **I CONSENT TO THE RELEASE** of the information contained in this form to my Employer/Policyholder and the Company, its employees, agents, reinsurers and service providers for the purposes of underwriting, administration and the processing of this claim.

If my Social Insurance Number is used as my identification number, **I AUTHORIZE** its use for the administration of my group benefits.

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

Member's signature _____ Date Y M D

Address _____ Telephone

PHYSICIAN'S STATEMENT ON THE REVERSE SIDE

PART C - ATTENDING PHYSICIAN'S STATEMENT

1. Name of patient _____ Age _____

2. a) Date first consulted for the injury described Y M D _____ b) Date of last treatment Y M D _____

3. Describe the exact nature, location and extent of injuries sustained: _____

_____

4. a) If the accident caused the partial or total loss of a limb, indicate on the diagram below where the amputation was made.

b) Is this total and permanent loss of use? ❒ No ❒ Yes, specify _____

5. Give the date of the amputation or loss of use Y M D _____

6. If the injury resulted in total and irrecoverable loss of sight of either or both eyes, give date on which this loss occurred Y M D _____

a) If the injury necessitated removal of either or both eyes, give date of removal Y M D _____

b) What was the level of vision in each eye prior to the accident? Left _____ Right _____

c) What percentage of vision, if any, now remains in each eye? Left _____ Right _____

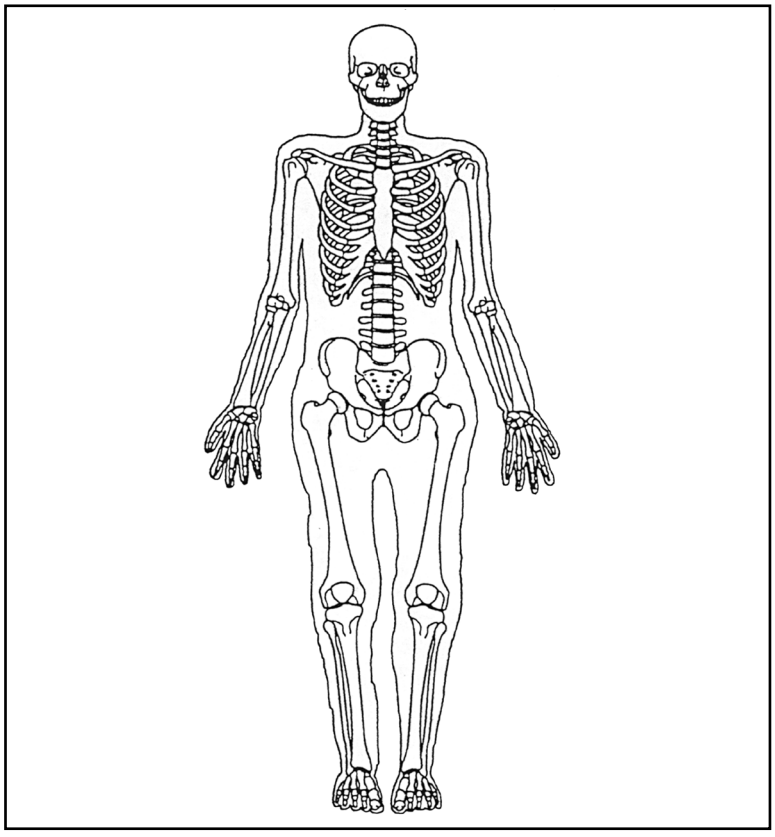
7. If the injury resulted in total and irrecoverable loss of hearing and speech, give date on which this loss occurred Y M D _____

8. Was the injury described solely responsible for the loss? ❒ Yes ❒ No

If no, give particulars of any contributing cause or causes: _____

_____

PLEASE INDICATE ON THE DIAGRAM BELOW AT WHERE THE AMPUTATION WAS MADE.



Attending physician's signature _____ Date Y M D _____

Attending physician's address _____