iA Financial Group

NURSING CARE QUESTIONNAIRE

GROUP INSURANCE

Quebec
Group Health and Dental Claims
PO Box 800, Station Maison de la Poste
Montreal, Quebec H3B 3K5

All Other Provinces
Group Health and Dental Claims
PO Box 4643, Station A
Toronto, Ontario M5W 5E3

INSTRUCTIONS

1. The details requested in this form are required in order for iA Financial Group to determine the eligibility of your request for reimbursement under the nursing care benefit. For prior approval, please forward this form to the address indicated above. You will then receive a confirmation letter from iA Financial Group concerning your request once the review has been completed.
2. Please ensure that the attending physician completes the "TO BE COMPLETED BY THE ATTENDING PHYSICIAN" section on the following page of this form.
3. Some financial assistance programs are available for home care services. You must register for these programs, based on your territory, if the care is needed for more than two weeks.

Quebec residents: Integrated Health and Social Services Centres (CISSS or CIUSSS) or Local Community Services Centres (CLSC)
Ontario residents: Home and Community Care Support Services (HCCSS)
Other provinces residents: Please verify if there are organizations in your province that offer such programs and register for them, if applicable

TO BE COMPLETED BY THE PLAN MEMBER (PLEASE PRINT CLEARLY)

1. BASIC INFORMATION

Policy no. _______________ Certificate no. ______________________________

Plan member's first name ____________________ Last name ____________________

If this request is for your spouse or dependent child, specify:

Patient's first name ____________________ Last name ____________________

Relationship to the plan member ____________________ Date of birth Y | M | D

2. PLACE OF RESIDENCE OF THE PERSON REQUIRING NURSING CARE

Are the expenses for nursing care for someone residing in:

A public long-term care facility (e.g., CHSLD)? ☐ No ☐ Yes, provide the name ____________________

A private long-term care facility? ☐ No ☐ Yes, provide the name ____________________

A public nursing home? ☐ No ☐ Yes, provide the name ____________________

A private nursing home? ☐ No ☐ Yes, provide the name ____________________

Other? ☐ No ☐ Yes, specify ____________________

Provide the specific address, according to the choice selected above ____________________

3. WHERE SERVICES WILL BE PROVIDED

Services will be provided at: ☐ Hospital ☐ Long-term care facility/CHSLD ☐ Nursing home

Other, specify ____________________

4. NATURE OF FEES

Are the fees to be incurred for nursing services related to: a work accident? ☐ Yes ☐ No a car accident? ☐ Yes ☐ No

Other, specify ____________________

Date of the accident Y | M | D

5. PLAN MEMBER CONFIRMATION / AUTHORIZATION

If this questionnaire is being submitted in respect of my spouse or dependent child, **I CONFIRM** that I am authorized to disclose information about him/her in regards to the nursing care services to be or being received.

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, public or private organization or institution to disclose to Industrial Alliance Insurance and Financial Services inc. ("iA Financial Group"), its employees, agents, reinsurers and service providers any information which they may need in the assessment of the information contained in this questionnaire in order to determine eligibility for the nursing care benefit.

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.

Plan member signature ____________________ Date Y | M | D

THE FOLLOWING PAGE OF THIS FORM MUST ALSO BE COMPLETED AND SIGNED.

TO BE COMPLETED BY THE ATTENDING PHYSICIAN (PLEASE PRINT CLEARLY)

1. PATIENT CLINICAL INFORMATION

Patient's first name ____________________ Last name ____________________

Please provide a brief summary of the patient's condition/diagnosis requiring nursing care ____________________

Prognosis ____________________

Amount of care required: Hours per day __________ Days per week __________

Expected duration of care: From Y M D to Y M D

Level of care required: ☐ RN ☐ LPN ☐ Other, specify ____________________

Location where services will be provided ____________________

Type of medication, route of administration and frequency – Attach extra sheets, if necessary.

Medication	Route of administration	Frequency

Specific duties to be performed by the nurse ____________________

Additional comments ____________________

2. CONFIRMATION AND IDENTIFICATION OF THE ATTENDING PHYSICIAN

I hereby confirm that the above information is true and complete to the best of my knowledge.

Physician's first name ____________________ Last name ____________________ Licence no. ____________________

☐ General practitioner ☐ Specialist ☐ Other, specify ____________________

Address ____________________ Postal code

Telephone ____________________ Fax ____________________

Signature ____________________ Date Y M D