

4. 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:

Transit # Institution # Account #

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.

5. MEMBER CONFIRMATION/AUTHORIZATION

I HEREBY CONFIRM:

1. that the information contained in this claim form is true and complete to the best of my knowledge;
2. that the persons for whom I am making a claim are eligible and that if the claim is being made on behalf of a dependent, I am AUTHORIZED to disclose information about him/her with respect to the claim; and
3. that if the claim is being made under my Health Spending Account
 - (I) that the expenses are not eligible for reimbursement under the group policy with Industrial Alliance Insurance and Financial Services Inc. (iA Financial Group) or any other plan;
 - (II) the expenses being claimed qualify for reimbursement under my Health Spending Account;
 - (III) that I understand that any expenses for which I am reimbursed under my Health Spending Account cannot be claimed for income tax purposes and should any tax consequences arise from the reimbursement of these expenses, I am responsible for payment of such taxes.

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 **AGREE** 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.

On behalf of myself and my dependents:

1. **I CONSENT TO THE RELEASE** of the information contained in this claim form to iA Financial Group, its employees, agents, reinsurers, service providers and other organizations working with iA Financial Group for the purposes of underwriting, administration and processing of the claim; and
2. **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, private or public organization or institution to disclose to iA Financial Group, its employees, agents and service providers any information regarding the treatment and expenses incurred which they may need in the assessment of the claim.
3. **I UNDERSTAND AND AUTHORIZE** that in the event there is reasonable suspicion of or any evidence of fraud or abuse regarding the claim, iA Financial Group will have the right to use and exchange any information related to the claim with any relevant regulatory, investigative or government body, any healthcare provider or professional medical organization, insurance company or reinsurer, the policyholder, my employer or any other party as provided by law for the purpose of investigating any such fraud or abuse.

I UNDERSTAND that personal information may be subject to disclosure to those authorized under the applicable laws within or outside of Canada.

I AUTHORIZE iA Financial Group to release to my employer/policyholder the amount of my account balance under the Health Spending Account when required for the provision/management of the Health Spending Account.

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

Member's signature _____ Date

Y	M	D

CLAIMS SUBMISSION GUIDELINES

General Information

Industrial Alliance Insurance and Financial Services Inc. forms	<ul style="list-style-type: none"> Forms for other claim types, questionnaires and more information can be found on our website at: ia.ca.
Coordination of benefits	<ul style="list-style-type: none"> This establishes the order in which two or more insurance companies will pay benefits for the same claim (maximum 100%). For detailed instructions and scenarios regarding coordination of benefits, please refer to the "Coordination of Benefits Guide" available on our website.
Claims related to a work or motor vehicle accident	<ul style="list-style-type: none"> If your claim is related to a work accident, please submit the initial claim to your provincial Worker's Compensation Board if applicable. If your claim is related to a motor vehicle accident, please submit the initial claim to your motor vehicle insurance, if applicable.
Expenses incurred outside of Canada	<ul style="list-style-type: none"> Expenses incurred outside of Canada are handled by CanAssistance. The travel insurance claim forms from CanAssistance, specific to your province of residence, can be found on our website at ia.ca. For any inquiries or questions, please contact CanAssistance at 1 800 203-9024.

Claim Requirements

Original detailed receipts should include the following	<ul style="list-style-type: none"> Claimant's full name Date, cost and type of treatment Supplier or provider's name and credentials
Paramedical services (e.g. massage therapy, physiotherapy, chiropractic, etc.)	<ul style="list-style-type: none"> Original detailed receipt including medical referral if required by your group policy
Foot orthotics	<ul style="list-style-type: none"> Original detailed receipt Casting technique Credentials of qualified health practitioner who performed the casting (chiropodist, chiropractor, orthotist, pedorthist, physiotherapist or podiatrist)
Orthopedic shoes	<ul style="list-style-type: none"> Original detailed receipt Medical referral from a medical doctor, podiatrist, chiropodist, physiotherapist or chiropractor
Hospital beds & wheelchairs	<ul style="list-style-type: none"> Original detailed receipt including breakdown of charges Medical referral with diagnosis and symptoms Expected length of time required Purchase date of previous appliance, if applicable
Orthopedic appliances (e.g. knee & back braces)	<ul style="list-style-type: none"> Original detailed receipt specifying the type of appliance Medical referral with diagnosis and symptoms Expected length of time required
Nursing care	<ul style="list-style-type: none"> The nursing care benefit requires pre-approval from us. Please download and complete the Nursing Care Questionnaire from our website and submit it to Industrial Alliance Insurance and Financial Services Inc.