

CLAIM FORM - HEALTH SPENDING ACCOUNT MEDICAL/DENTAL



Depending on your province of residence, please submit form to:

Quebec

Date of accident ____

Ontario, Atlantic and Western Provinces

一路	GROUP INSURANCE
----	--------------------

☐ Claim ☐ Estimate

	Toronto, Ontario N	IDW DED						
1. PRIMARY MEMBER IN	NFORMATION							
ember's last name			First	name				
oup policy no	Certificate no	Com	npany/A	ssociation na	me			
ate of birth	D	x:	-	nguage: 🗌 E				
eferred method of contact for the	e purpose of claims resolutio	n:			Ü			
Telephone			ddress .					
Complete this section only if yo Member's address	,	hanged.					de	
2. COORDINATION OF E	BENEFITS (Complete this	s section only if your s	spouse o	r dependent (children ar	e covered by anothe	er group plan.)	
If your spouse or dependent child may subsequently submit a claim reimburse fees only after the c If your insured dependent children first during a calendar year. your spouse or dependent children to the control of	n to Industrial Alliance Insurar oordination of benefits has n are covered under your plan	nce and Financial Service been considered, if ap as well as under your s	ces Inc. fo pplicable pouse's g	or the unpaid p Iroup plan, the	oortion, if ap	plicable. Your Health be submitted to the pla	Spending Account can	be us hday c
• •		Coverage:				☐ Tes, please C	ompiete the informatio	ii belo
ame of insured spouse/child	Dental Dotti	Coverage.	mun	nuuai 🗀 F	arrilly	Date	of hirth	M
e you claiming any expenses	for your spouse or depend	dent children that are	NOT CO	vered under t	heir plan?	Date C	of Diffit	
No Yes, please specify	, , ,							
vour spouse's group insurance	ce carrier is also Industrial	Alliance Insurance a	and Fina			vou want us to app	ly coordination of bene	efits?
	ce carrier is also Industrial Spouse's group policy no			ncial Service	s Inc., do			
No Yes, please specify:	Spouse's group policy no			ncial Service	s Inc., do			
No Yes, please specify: B. EXPENSES TO BE RE For medical expenses, attach from the other group insurance	Spouse's group policy no SIMBURSED the original receipts. For detection of the carrier if Industrial Alliance	ental care, attach the c	dentist's incial Se	ncial Service	s Inc., do	Certificate no	copy of the explanation	of be
No Yes, please specify: 3. EXPENSES TO BE RE For medical expenses, attach from the other group insurance coordination of benefits and in the latth Spending Account (Please indicate which expenses Medical and dental expenses	Spouse's group policy not the original receipts. For detecarrier if Industrial Allian accome tax purposes. The recome tax purposes are recomed to the company of the compan	ental care, attach the c ce Insurance and Fina eceipts will not be retu npaid portion paid ur	dentist's incial Se irned to	form. In both rvices Inc. is you, and they	cases, you not the pri will be des	Certificate no must also attach a mary insurer. Keep a stroyed 60 days after	copy of the explanation a copy of the receipts for r receipt. column for each expen	of be or the
No Yes, please specify: B. EXPENSES TO BE RE For medical expenses, attach from the other group insurance coordination of benefits and in the latth Spending Account (Please indicate which expenses dedical and dental expenses	Spouse's group policy not the original receipts. For detecarrier if Industrial Allian accome tax purposes. The recome tax purposes are recomed to the company of the compan	ental care, attach the c ce Insurance and Fina eceipts will not be retu npaid portion paid ur	dentist's incial Se irned to	form. In both rvices Inc. is you, and they	cases, you not the pri will be desecting yes olicy may	Certificate no must also attach a mary insurer. Keep a stroyed 60 days after	copy of the explanation a copy of the receipts for r receipt. column for each expen	of be or the se. d by t
No Yes, please specify: B. EXPENSES TO BE REFor medical expenses, attach from the other group insurance coordination of benefits and in Health Spending Account (Please indicate which expensed Medical and dental expenses income Tax Act.	Spouse's group policy not the original receipts. For detecarrier if Industrial Allian accome tax purposes. The recome tax purposes are recomed to the company of the compan	ental care, attach the c ce Insurance and Fina eceipts will not be retu npaid portion paid ur	dentist's incial Se irned to	form. In both rvices Inc. is you, and they ar HSA by chayour group p	cases, you not the pri will be desecting yes olicy may	Certificate no I must also attach a mary insurer. Keep a stroyed 60 days after a corno in the HSA of the considered under the considered and the considered are considered.	copy of the explanation a copy of the receipts for receipt. column for each expener your HSA as outline	of be or the
No Yes, please specify: B. EXPENSES TO BE RE For medical expenses, attach from the other group insurance coordination of benefits and in the least indicate which expenses dedical and dental expenses income Tax Act.	Spouse's group policy not state original receipts. For detection of the original receipts. For detection of the original receipts. For detection of the original receipts of the original receipts. The results of the original receipts of the original receipts. The original receipts of the original receipts of the original receipts. The original receipts of the original receipts of the original receipts. For detection of the original receipts of the original receipts. For detection or the original receipts of the original receipts. For detection or the original receipts of the original receipts. The original receipts of the original receipts of the original receipts of the original receipts. The original receipts of the original receipts o	ental care, attach the control care, attach the control care and Final eccepts will not be returned portion paid until covered only partially covered	dentist's incial Se irned to	form. In both rvices Inc. is you, and they ar HSA by chayour group p	cases, you not the pri will be desecting yes olicy may	Certificate no	copy of the explanation a copy of the receipts for receipt. column for each expen er your HSA as outline	of be or the
No Yes, please specify: B. EXPENSES TO BE REFORMED AND TO BE REFORMED. INTERPRETAND TO BE REFORMED AND TO	Spouse's group policy not state original receipts. For detection of the original receipts. For detection of the original receipts. For detection of the original receipts of the original receipts. The results of the original receipts of the original receipts. The original receipts of the original receipts of the original receipts. The original receipts of the original receipts of the original receipts. For detection of the original receipts of the original receipts. For detection or the original receipts of the original receipts. For detection or the original receipts of the original receipts. The original receipts of the original receipts of the original receipts of the original receipts. The original receipts of the original receipts o	ental care, attach the ce insurance and Fina eceipts will not be retungated portion paid ur only partially covered. Date of birth	dentist's incial Se irned to inder you d under	form. In both rvices Inc. is you, and they ar HSA by chayour group p	cases, you not the pri will be desecting yes olicy may	Certificate no	copy of the explanation a copy of the receipts for receipt. column for each expener your HSA as outline	of be or the
No Yes, please specify: B. EXPENSES TO BE RE For medical expenses, attach from the other group insurance coordination of benefits and in the least indicate which expenses dedical and dental expenses income Tax Act.	Spouse's group policy not state original receipts. For detection of the original receipts. For detection of the original receipts. For detection of the original receipts of the original receipts. The results of the original receipts of the original receipts. The original receipts of the original receipts of the original receipts. The original receipts of the original receipts of the original receipts. For detection of the original receipts of the original receipts. For detection or the original receipts of the original receipts. For detection or the original receipts of the original receipts. The original receipts of the original receipts of the original receipts of the original receipts. The original receipts of the original receipts o	ental care, attach the ce insurance and Fina eceipts will not be retungated portion paid ur only partially covered. Date of birth	dentist's incial Se irned to inder you d under	form. In both rvices Inc. is you, and they ar HSA by cheyour group p Children 18 a Handicapped child Yes No	cases, you not the pri will be desecking yes colicy may	Certificate no	copy of the explanation a copy of the receipts for receipt. column for each expener your HSA as outline Total expenses (Per claimant)	of be se. d by t
No Yes, please specify: B. EXPENSES TO BE RE For medical expenses, attach from the other group insurance coordination of benefits and in the least indicate which expenses the	Spouse's group policy not state original receipts. For detection of the original receipts. For detection of the original receipts. For detection of the original receipts of the original receipts. The results of the original receipts of the original receipts. The original receipts of the original receipts of the original receipts. The original receipts of the original receipts of the original receipts. For detection of the original receipts of the original receipts. For detection or the original receipts of the original receipts. For detection or the original receipts of the original receipts. The original receipts of the original receipts of the original receipts of the original receipts. The original receipts of the original receipts o	ental care, attach the ce insurance and Fina eceipts will not be retungated portion paid ur only partially covered. Date of birth	dentist's incial Se irned to inder you d under	form. In both rvices Inc. is you, and they ar HSA by chayour group p Children 18 a Handicapped child Yes No	cases, you not the pri will be desecking yes olicy may	Certificate no	copy of the explanation a copy of the receipts for receipt. column for each expenser your HSA as outline Total expenses (Per claimant)	of be or the
No Yes, please specify: 3. EXPENSES TO BE RE For medical expenses, attach from the other group insurance coordination of benefits and in Health Spending Account (Please indicate which expensed Medical and dental expenses income Tax Act. Name	Spouse's group policy not state original receipts. For detection of the original receipts. For detection of the original receipts. For detection of the original receipts of the original receipts. The results of the original receipts of the original receipts. The original receipts of the original receipts of the original receipts. The original receipts of the original receipts of the original receipts. For detection of the original receipts of the original receipts. For detection or the original receipts of the original receipts. For detection or the original receipts of the original receipts. The original receipts of the original receipts of the original receipts of the original receipts. The original receipts of the original receipts o	ental care, attach the ce insurance and Fina eceipts will not be retungated portion paid ur only partially covered. Date of birth	dentist's incial Se irned to inder you d under	form. In both rvices Inc. is you, and they ar HSA by chayour group p Children 18 a Handicapped child Yes No	cases, you not the pri will be desecting yes olicy may	Certificate no	copy of the explanation a copy of the receipts for receipt. column for each expender your HSA as outline Total expenses (Per claimant)	of be

If the dental claim is the result of an accident, please complete the Claim Form – Dental Care in case of an accident (F54-267A), which can be found on our website.

Other _____

4. 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. (the "Company") 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.

On behalf of myself and my dependents:

- 1. I CONSENT TO THE RELEASE of the information contained in this claim form to the Company, its employees, agents, reinsurers, service providers and other organizations working with the Company 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 the Company, 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, the Company 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 the Company 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.

		Y	M	D
Member's signature X	Date _	1 1		

CLAIMS SUBMISSION GUIDELINES

General Information

Industrial Alliance Insurance and Financial Services Inc. forms	Forms for other claim types, questionnaires and more information can be found on our website at: ia.ca
Coordination of benefits	 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	 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	• 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	 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.)	Original detailed receipt including medical referral if required by your group policyy
Foot orthotics	 Original detailed receipt Casting technique Credentials of qualified health practitioner who performed the casting (chiropodist, chiropractor, orthotist, pedorthist, physiotherapist or podiatrist)
Orthopedic shoes	Original detailed receipt Medical referral from a medical doctor, podiatrist, chiropodist, physiotherapist or chiropractor
Hospital beds & wheelchairs	 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)	 Original detailed receipt specifying the type of appliance Medical referral with diagnosis and symptoms Expected length of time required
Nursing care	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.