INDUSTRIAL ALLIANCE
INSURANCE AND FINANCIAL SERVICES INC.

www.inalco.com

GROUP INSURANCE

According to your province of residence, please submit form to:

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

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

CLAIM FORM – HEALTH SPENDING ACCOUNT

MEDICAL/DENTAL

☐ **Claim** ☐ **Estimate**

1. PRIMARY MEMBER INFORMATION

Member's last name _____ First name _____

Group policy no. _____ Certificate no. _____ Company/Association name _____

Date of birth Y M D Sex: ☐ M ☐ F Language: ☐ English ☐ French

Preferred method of contact for the purpose of claims resolution:

☐ Telephone _____ ☐ Email address _____

Complete this section only if your information has recently changed.

Member's Address _____ Postal Code _____

2. COORDINATION OF BENEFITS (Complete this section only if your spouse or dependent children are covered by another group plan.)

- If your spouse or dependent children are covered under their own group plan for medical or dental benefits, the claim must first be submitted to his/her group insurance carrier. You may subsequently submit a claim to Industrial Alliance for the unpaid portion, if applicable. **Your Health Spending Account can be used to reimburse fees only after the coordination of benefits has been considered, if applicable.**
- If your insured dependent children are covered under your plan as well as under your spouse's group plan, the claim must be submitted to the plan of the parent whose birthday comes first during a calendar year.

Is your spouse or dependent child(ren) covered by another group plan for medical or dental benefits? ☐ No ☐ Yes, please complete the information below.

Benefit types: ☐ Medical ☐ Dental ☐ Both Coverage: ☐ Individual ☐ Family

Name of insured spouse/child _____ Date of birth Y M D

Are you claiming any expenses for your spouse or dependent children that are **NOT** covered under their plan?

☐ No ☐ Yes, please specify the benefit: _____

If your spouse's group insurance carrier is also Industrial Alliance, do you want us to apply coordination of benefits? ☐ No ☐ Yes, please specify:

Spouse's group policy no. _____ Certificate no._____

3. EXPENSES TO BE REIMBURSED

- **For medical expenses, attach the original receipts. For dental care, attach the dentist's form. In both cases, you must also attach a copy of the explanation of benefits from the other group insurance carrier if Industrial Alliance is not the primary insurer. Keep a copy of the receipts for the coordination of benefits and income tax purposes. The receipts will not be returned to you, and they will be destroyed 60 days after receipt.**

***Health Spending Account (HSA)**
Please indicate which expenses you wish to have the unpaid portion paid under your HSA by checking yes or no in the HSA column for each expense. Medical and dental expenses which are not covered or only partially covered under your group policy may be considered under your HSA as outlined by the Income Tax Act.

Name (One line per claimant)	Relationship to member	Date of birth	Children 18 and over (or according to your plan)			Total expenses (Per claimant)	HSA*
			Handicapped child	Full-time student	Name of school		
		Y M D	Yes No	Yes No			Yes No
			☐☐	☐☐		$	☐☐
			☐☐	☐☐		$	☐☐
			☐☐	☐☐		$	☐☐
			☐☐	☐☐		$	☐☐
			☐☐	☐☐		$	☐☐

If the medical claim is the result of an accident, please specify type of accident (details on reverse side, if applicable): ☐ Work ☐ Motor vehicle

Date of accident Y M D ☐ Other _____

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.

Continued on the next page

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 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 Industrial Alliance, its employees, agents, reinsurers, service providers and other organizations working with Industrial Alliance 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 Industrial Alliance, 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, Industrial Alliance 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 Industrial Alliance 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 **X**_____ Date Y M D

INDUSTRIAL ALLIANCE CLAIMS SUBMISSION GUIDELINES

General Information

Industrial Alliance Forms	• Forms for other claim types, questionnaires and more information can be found on our website at: **www.inalco.com**
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 the Industrial Alliance website. 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 policy
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 Industrial Alliance. Please download and complete the Nursing Care Questionnaire from our website and submit it to Industrial Alliance.