

CLAIM FORM - HEALTH SPENDING ACCOUNT MEDICAL/DENTAL



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

Group Health and Dental Claims PO Box 800, Station Maison de la Poste

Date of accident

Ontario, Atlantic and Western Provinces Group Health and Dental Claims PO Box 4643, Station A

الظاا	INSURANCE

☐ Claim ☐ Estimate

4 DOMARY MEMBER IN								
1. PRIMARY MEMBER IN	IFORMATION							
Member's last name			First	name				
Group policy no	Certificate no	Cor	npany/As	ssociation na	me			
Date of birth Y M	Se Se	ex: \square M \square F		guage: 🗌 E	_	_		
Preferred method of contact for the Telephone			ddress _					
Complete this section only if you Member's address	,	o .				Postal co	de	
2. COORDINATION OF B	SENEFITS (Complete thi	s section only if your	spouse o	r dependent o	children ar	e covered by anoth	er group plan.)	
 If your spouse or dependent child may subsequently submit a claim reimburse fees only after the co If your insured dependent childrer first during a calendar year. 	n to Industrial Alliance Insura pordination of benefits has n are covered under your plan	nce and Financial Servi been considered, if a as well as under your s	ices Inc. fo pplicable. spouse's g	or the unpaid proup plan, the	oortion, if ap	plicable. Your Health	n Spending Account can	be used the
Is your spouse or dependent ch		•	_	_		☐ Yes, please of	complete the informatio	n below.
Benefit types:	☐ Dental ☐ Both	Coverage:	☐ Indiv	idual \square F	amily		, Y ,	M D
Name of insured spouse/child						Date	of birth Y	
Are you claiming any expenses								
No ☐ Yes, please specify t	he benefit:							
f your spouse's group insurance	ce carrier is also Industria	I Alliance Insurance	and Fina	ncial Service	s Inc., do	you want us to app	ly coordination of bene	fits?
\square No \square Yes, please specify:	Spouse's group policy no	o				Certificate no		
3. EXPENSES TO BE RE	IMBURSED							
For medical expenses, attach to from the other group insurance.	the original receipts. For d	ental care, attach the						
coordination of benefits and in	e carrier if Industrial Allian	ce Insurance and Fina	ancial Ser	vices Inc. is	not the pri	mary insurer. Keep	a copy of the receipts for	
	e carrier if Industrial Allian acome tax purposes. The r HSA) es you wish to have the u	ce Insurance and Fina eceipts will not be retu unpaid portion paid u	ancial Ser urned to y nder you	vices Inc. is you, and they r HSA by ch	not the pri will be des	mary insurer. Keep stroyed 60 days afte or no in the HSA	a copy of the receipts for receipt.	or the
*Health Spending Account (Please indicate which expenses Medical and dental expenses Income Tax Act.	e carrier if Industrial Allian acome tax purposes. The r HSA) es you wish to have the u	ce Insurance and Fina eceipts will not be retu inpaid portion paid u only partially covere	ancial Ser urned to y nder you d under y	vices Inc. is you, and they r HSA by choor group p	not the pri will be des ecking yes olicy may	mary insurer. Keep stroyed 60 days afte or no in the HSA	a copy of the receipts for receipt. column for each expener your HSA as outline	se. d by the
*Health Spending Account (Please indicate which expenses Medical and dental expenses Income Tax Act.	e carrier if Industrial Allian acome tax purposes. The r HSA) es you wish to have the u	ce Insurance and Fina eceipts will not be retu unpaid portion paid u	ancial Ser urned to y nder you d under y	vices Inc. is you, and they r HSA by cho your group p	not the pri will be des ecking yes olicy may	mary insurer. Keep stroyed 60 days afte or no in the HSA be considered und	a copy of the receipts for receipt.	or the
*Health Spending Account (Please indicate which expenses Medical and dental expenses Income Tax Act.	e carrier if Industrial Allian come tax purposes. The r HSA) es you wish to have the u which are not covered or	ce Insurance and Fina eceipts will not be retu inpaid portion paid u only partially covere	ancial Ser urned to y nder you d under y	r HSA by cheyour group p Children 18 a Handicapped	not the pri will be des ecking yes olicy may	mary insurer. Keep stroyed 60 days after or no in the HSA be considered und	a copy of the receipts for receipt. column for each expener your HSA as outline Total expenses	se. d by the
*Health Spending Account (Please indicate which expenses Medical and dental expenses Income Tax Act.	e carrier if Industrial Allian come tax purposes. The r HSA) es you wish to have the u which are not covered or	ce Insurance and Fina eceipts will not be retu inpaid portion paid u only partially covere	ancial Ser urned to y nder you ed under y	r HSA by cheyour group p Children 18 a Handicapped child	not the pri will be des ecking yes olicy may	mary insurer. Keep stroyed 60 days after or no in the HSA be considered und	a copy of the receipts for receipt. column for each expener your HSA as outline Total expenses	se. d by the
Health Spending Account (Please indicate which expenses Medical and dental expenses Income Tax Act.	e carrier if Industrial Allian come tax purposes. The r HSA) es you wish to have the u which are not covered or	ce Insurance and Fina eceipts will not be retu inpaid portion paid u only partially covere	ancial Ser urned to y nder you ed under y	r HSA by cheyour group p Children 18 a Handicapped child Yes No	not the pri will be des ecking yes olicy may nd over (or a Full-time student Yes No	mary insurer. Keep stroyed 60 days after or no in the HSA be considered und	a copy of the receipts for receipt. column for each expener your HSA as outline Total expenses (Per claimant)	se. d by the HSA
Health Spending Account (Please indicate which expenses Medical and dental expenses Income Tax Act.	e carrier if Industrial Allian come tax purposes. The r HSA) es you wish to have the u which are not covered or	ce Insurance and Fina eceipts will not be retu inpaid portion paid u only partially covere	ancial Ser urned to y nder you ed under y	r HSA by cheyour group p Children 18 a Handicapped child Yes No	not the pri will be des ecking yes olicy may	mary insurer. Keep stroyed 60 days after or no in the HSA be considered und	a copy of the receipts for receipt. column for each expener your HSA as outline Total expenses (Per claimant)	se. d by the HSA Yes No
Health Spending Account (Please indicate which expenses Medical and dental expenses Income Tax Act.	e carrier if Industrial Allian come tax purposes. The r HSA) es you wish to have the u which are not covered or	ce Insurance and Fina eceipts will not be retu inpaid portion paid u only partially covere	ancial Ser urned to y nder you ed under y	r HSA by cheyour group p Children 18 a Handicapped child Yes No	not the pri will be des ecking yes olicy may	mary insurer. Keep stroyed 60 days after or no in the HSA be considered und	a copy of the receipts for receipt. column for each expener your HSA as outline Total expenses (Per claimant)	HSA

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.