

According to your region, please submit complete form to:

Quebec PO Box 800, Station Maison de la Poste Montreal, Quebec H3B 3K5	All Other Provinces PO Box 4643, Station A Toronto, Ontario M5W 5E3
---	--

1. MEMBER INFORMATION

Policyholder's name _____ Policy no. _____

Member's last name _____ First name _____

Certificate no. _____ Date of birth

Y	M	D

 Sex: M F Language: E F

2. EXPENSES TO BE REIMBURSED

Please attach original receipts for all expenses to be reimbursed. Keep a copy of all receipts as they will not be returned and will be destroyed 60 days after the date they were received by iA Financial Group.

DESCRIPTION OF EXPENSE	AMOUNTS TO BE REIMBURSED FOR EACH EXPENSE
_____	\$ _____
_____	\$ _____
_____	\$ _____
_____	\$ _____
Total	\$ _____

3. MEMBER CONFIRMATION/AUTHORIZATION

I HEREBY CONFIRM that the information contained in this claim form is true and complete to the best of my knowledge and that the expenses were incurred by myself.

I RELEASE the information contained in this claim form to Industrial Alliance Insurance and Financial Services Inc. (the "Company"), its employees, agents, reinsurers and service providers for the purposes of underwriting, administration and processing of the claim.

I AUTHORIZE any healthcare provider or professional, medical organization, insurance or reinsurance company, workers' compensation board, the policyholder, my employer, and any other person, private or public organization or institution to disclose to the Company, its employees, agents, reinsurers and service providers any information regarding the expenses which they may need in the assessment of the claim.

I AUTHORIZE the Company to release to my employer/policyholder the amount of my account balance under the wellness account when required for the provision/management of the wellness account.

I AUTHORIZE the use of my Social Insurance Number as an identification number when it is required for the administration of the wellness account.

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

Member's signature **X** _____ Date _____

Address _____ Postal code _____