

This document addresses frequently asked questions about Blanket Student Accident Insurance claims.

MEDICAL INJURY CLAIMS

- The Blanket Student Accident Insurance Standard Claim Form must be completed in full in order to process your claim. Please be sure to include the **Attending Physician's Statement** section which must be completed by the attending physician (MD) who first saw the insured within 30 days of the injury. Chiropractors, Physiotherapists, Registered Nurses, or any other service providers are **not eligible** to complete the form.
- In the event that the insured was initially seen in a hospital, a copy of the Hospital Admission or Emergency Room Report may be submitted instead of the Attending Physician's Statement. If you are claiming for the expense of an ambulance only, we **do not** require the attending Physician's Statement (nor the Hospital Admissions Report). Submit the original Ambulance invoice together with the top parts of the Student Accident claim form.
- If your policy provides **Physiotherapy coverage**, claims for these items must be accompanied by the original receipts and the written referral from the attending physician recommending physiotherapy treatment.
- If your policy provides coverage for **Brace expenses**, claims for these items must be accompanied by the original receipts and the written referral from the attending physician indicating that the brace is required for therapeutic or curative purposes only.

DENTAL INJURY CLAIMS

- The Blanket Student Accident Insurance Standard Claim Form must be completed in full in order to process your claim. If claiming for dental injury, please be sure that both the **Part 1 & Part 2 Dentist** sections on Page 2 of the claim form are completed by the attending dentist who saw the insured within 60 days of the injury.
- If you have more than one insurance carrier, please note that we require a detailed Explanation of Benefits from your primary carrier along with the completed claim form including the specific dental procedure and tooth codes.

IMPORTANT

- The Blanket Student Accident Insurance Standard Claim Form must be filed with Industrial Alliance Insurance and Financial Services Inc., within 90 days of the date of the injury, regardless of whether expenses have been incurred. Attach only original receipts for all eligible expenses being claimed.
- Please note that it is the responsibility of the Parent/Legal Guardian to obtain and forward the completed claim form as indicated. Any charge incurred for its completion is also the responsibility of the Parent/Legal Guardian.
- If you have more than one insurance carrier, benefits are coordinated. Please submit your expenses to your other insurance company first. Once you have received a copy of the Explanation of Benefits, please forward to Industrial Alliance with copies of expenses.
- Please note: In providing this claim form for the convenience of the claimant, Industrial Alliance does not admit any liability or waive any of the terms and conditions of the policy. Provision of this claim form does not indicate coverage. Only eligible claims will be paid.
- If you have any questions regarding coverage, your claim or require additional information, please contact our office at 1-800-266-5667 for instructions and information.

Return completed claim form to:
INDUSTRIAL ALLIANCE INSURANCE AND FINANCIAL SERVICES INC.
Claims Department, 2165 Broadway W, PO Box 5900, Vancouver, BC, V6B 5H6
Tel: 1-800-266-5667
www.inalco.com

Blanket Student Accident Insurance Standard Claim Form

It is the responsibility of the parent to obtain and forward the completed claim form as indicated, and for any charge made for its completion.

Please print in ink

Please Tell Us About Yourself

| | | | | | |
|---|------------|------------------|---|------------|------------|
| Name of Parent or Legal Guardian (please print) | | | Insured's Information (Print) | | |
| Last Name | First Name | Initials | Last Name | First Name | Initials |
| Address | | | Date Of Birth | Sex | |
| City | | | <input type="checkbox"/> Male <input type="checkbox"/> Female | | Grade/Year |
| Province | | | Name Of School | | Policy # |
| Postal Code | | | Name Of School Board | | |
| Telephone (home) | | Telephone (work) | | | |

Please Tell Us About the Accident

| | | |
|---|---|--|
| Date of Accident | Time Of Accident | On what date was the Physician or Dentist first consulted for this injury? |
| <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="checkbox"/> am <input type="checkbox"/> pm | _____ |
| Where did the accident occur? | | Name & Address of Dentist or Physician: |
| _____ | | _____ |
| How did the accident happen? (Please provide a detailed explanation) | | Are any other hospital and medical or dental insurance benefits available? |
| _____ | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| What injuries were caused by the accident? | | If Yes: Name of other insuring company |
| _____ | | _____ |

- I hereby CERTIFY that the information contained in this Claim Form is true and complete to the best of my knowledge.
- On behalf of myself and/or any minor insured, I RELEASE the information contained in this Claim Form to Industrial Alliance Insurance and Financial Services Inc. and ACKNOWLEDGE that this information will be used to assess, process and administer this claim and policy coverage. I AUTHORIZE any health care provider, insurance company, school or school board, employer, or other person or other organization to disclose to Industrial Alliance any medical information, information regarding charges, or other information which Industrial Alliance may need in their assessment of this claim.
- I AUTHORIZE Industrial Alliance to exchange the information detailed in this Claim Form and other information contained in files related to this claim or coverage with any of the parties identified in the previous paragraph for the purposes listed above, or as authorized by me, or as legally required.

Dated this _____ of _____ Year _____ Claimant: _____
DAY MONTH YEAR (4 DIGITS) Signature of Parent or Legal Guardian or Insured

Attending Physician's Statement – (Must be Completed in Full and Signed by the Attending Physician)

Describe condition: _____ due to: Accident or Illness

Fracture Location & Type _____
and/or

Other Injury Location & Type _____

Referred for: Physiotherapy Massage Therapy ?

Date of onset of symptoms or injury: _____ Did any disease or previous injury contribute to loss? No Yes

If Yes, describe: _____ First date treated for this condition _____
(DD / MMM / YYYY)

Date of surgery _____ Under general anaesthetic or under local anaesthetic ? Was Claimant hospitalized? No Yes
(DD / MMM / YYYY)

Name of Hospital _____ Date Admitted _____
(DD / MMM / YYYY)

Hospital Address _____ Date Discharged _____
(DD / MMM / YYYY)

Date: _____
DD / MMM / YYYY NAME OF PHYSICIAN (please print) Signature of Attending Physician (M.D.)

Please Return To: Industrial Alliance Insurance and Financial Services Inc., Claims Department, 2165 Broadway W, PO Box 5900, Vancouver, BC V6B 5H6 1-800-266-5667

Important: Completed claim form must be filed with Industrial Alliance Insurance and Financial Services Inc., within 90 days after the date of the injury, and in no event later than 1 year, regardless of whether expenses have been incurred. Please attach original receipts for all eligible expenses being claimed. It is the entire responsibility of the parent to obtain and forward the completed claim form as indicated, and for any charge made for its completion.

Medical Injury Claims: The physician must complete the Attending Physician's (M.D.) Statement in order to process the claim. If claim involves physiotherapy or massage therapy expenses a copy of the Physician's referral for the therapy must accompany the completed claim form with receipts.

Dental Injury Claims: The reverse side of this form must be completed and signed by the dentist in order to process the claim.

Part 1 – Dentist

| | |
|---|---|
| Dentist Information Name _____ Address _____ City _____ Province _____ Postal Code _____ Telephone _____ | Patient Information Name _____ Address _____ City _____ Province _____ Postal Code _____ Telephone (home) _____ Telephone (work) _____ |
|---|---|

| Date of service | | | Int. Tooth Code | Procedure Code | Tooth Surfaces | Laboratory Charge | Dentist's Fee | Total Charge | |
|---|-------|------|-----------------|----------------|----------------|-------------------|-----------------------|--------------|--|
| Day | Month | Year | | | | | | | |
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| This is an accurate statement of services performed and fees charged E & OE | | | | | | | TOTAL SUBMITTED FEE → | | |

Are any dental benefits provided under any other private or government plan or policy?
 No Yes
 If yes, name of Plan/Company _____

Please do not forward x-rays, study models, or intra-oral photos unless requested by our office.

| | |
|---|---|
| Dentist's Signature _____ Date Day Month Year | I hereby assign benefits payable from this claim to the above named dentist and authorize payment directly to the dentist. Signature of subscriber _____ |
| I understand that the fees listed in this claim may not be covered by or may exceed my policy benefits. I understand that I am financially responsible to my dentist for the entire cost of the treatment, I authorize the release of the information contained in this claim form to my insuring company or agents. I also authorize the communication of information related to the coverage of services described in this form to the named dentist. | Signature of the Patient (or Parent/Legal Guardian) _____ |

Part 2 – Supplementary Dental Report (Must be Completed in Full)

1. Description of damage: _____

2. Teeth involved in the Accident: _____
3. Were these teeth whole or sound prior to the accident? No Yes If "No" Please indicate: _____
4. Is further treatment indicated? No Yes If "No" Please indicate: _____

| Int. Tooth Code | Treatment indicated – Use procedure code if possible | Est. Date – Treatment | | |
|-----------------|--|-----------------------|----------------|-----------------|
| | | Day D D | Month M M M | Year Y Y Y Y |
| | | | | |
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5. Describe further potential problems and indicate the time frame: _____
