iA Financial Group

CLAIM FORM
Accident / health insurance benefit

F13-1110A

1. PRIMARY MEMBER INFORMATION

Member's name: _____ Contract number: _____

Phone no.: Y Y Y Y M M D D Email address: _____

Date of birth:

Complete this section only if your information has recently changed.

Address: _____ Postal code:

2. PATIENT INFORMATION

Attach the original receipts and keep a copy for income tax purposes and coordination of benefits. The receipts will not be returned.

Name of patient	Date of birth	Relationship to member	For children over age 21, indicate whether a full-time student (you must include a full-time study certificate)	Amount
	Y Y Y Y M M D D		☐ Yes ☐ No	$
	Y Y Y Y M M D D		☐ Yes ☐ No	$
	Y Y Y Y M M D D		☐ Yes ☐ No	$
	Y Y Y Y M M D D		☐ Yes ☐ No	$

3. IN THE EVENT OF AN ACCIDENT ONLY

1. Was any care provided as the result of an accident? ☐ Yes Date of the event: Y Y Y Y M M D D ☐ No

2. Give a brief description of the circumstances of the accident (where and how):

_____

_____

4. COORDINATION OF BENEFITS

1. Are the attached receipts covered by: CNESST: ☐ Yes ☐ No SAAQ: ☐ Yes ☐ No

2. Are the attached receipts covered by another group insurance or individual insurance plan?

☐ Yes Name of the insurance company: _____ ☐ No

5. AMBULANCE TRANSPORT

If your claim includes a receipt for ambulance services, please state the medical reason for the transportation:

_____

_____

6. 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 the 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.

On behalf of myself and my dependents:

1. **I AUTHORIZE** iA Financial Group, its affiliates and its reinsurers to collect from any health care professional, public or private health or social services facility, the Régie de l'assurance maladie du Québec, any insurance company, financial institution, employer, former employer, MIB LLC, private investigator, group insurance administrator or private or public organization which holds personal or medical information about me, or to disclose information about me to them including my health status, medical history and any other information relevant for processing requests related to my claims.

   The personal information that we, iA Financial Group and our affiliates collect in connection with your request will be used and disclosed only for the purposes for which you have already consented.

   To review your consent preferences or to learn more, please consult our Privacy Notice at ia.ca/privacy-policy.

2. **I UNDERSTAND AND AUTHORIZE** that in the event there is reasonable suspicion of or any evidence of fraud or abuse regarding the claim, iA Financial Group 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 AGREE that a photocopy of this Confirmation/Authorization shall be as valid as the original.

Member's signature X _____ Date: Y Y Y Y M M D D

7. IMPORTANT NOTICE

To ensure prompt and efficient payment, please take note of the following:

— Submit your invoices on a regular basis or within 90 days of the date the services were rendered.

— Include only official, original receipts (these will not be returned). Duplicates and photocopies will not be accepted.

— The Primary Member must indicate all the information requested and sign the form.