iA Financial Group

PROVINCIAL REPLACEMENT PLAN – CLAIM FORM
MEDICAL EXPENSES

GROUP INSURANCE

Depending on 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

All other provinces
Group Health and Dental Claims
PO Box 4643, Station A
Toronto, Ontario M5W 5E3

☐ Claim ☐ Estimate

Print

1. PRIMARY MEMBER INFORMATION

Member's first name LIU Last name JIE

Policy no. 27019 Certificate no. 1332256 Company/Association name Tata Consultancy Services (TCS)

Date of birth (Y Y Y Y M M D D) 1964 02 03 Sex: ☒ M ☐ F Language: ☒ English ☐ French

Preferred method of contact for the purpose of claims resolution:

☐ Phone _____ ☐ Email address _____

Complete this section only if your information has recently changed.

Member's address _____ Postal code _____

2. MEDICAL EXPENSES

- To ensure the complete resolution of your claim, please provide the required information as outlined on the reverse side of this form.
- **Attach the original receipts and keep a copy for income tax purposes and the coordination of benefits. The receipts will not be returned and they will be destroyed 60 days after the received date.**

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

3. 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.

On behalf of myself and my dependents:

1. **I CONSENT TO THE RELEASE** of the information contained in this claim form to Industrial Alliance Insurance and Financial Services Inc. ("iA Financial Group"), its employees, agents, reinsurers, service providers and other organizations working with iA Financial Group for the purposes of underwriting, administration and processing of the claim.
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 iA Financial Group, 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, 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 UNDERSTAND that personal information may be subject to disclosure to those authorized under the applicable laws within or outside of Canada.

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) _____

For more information, please consult your benefits booklet.

CLAIM REQUIREMENTS

Original detailed receipts should include the following and must be submitted for each claim:	• The claimant's full name • The date, cost and type of treatment • The provider's name and professional title

If you have any questions or concerns, please contact Customer Service at 1-877-422-6487.