INDUSTRIAL ALLIANCE
INSURANCE AND FINANCIAL SERVICES INC.

Life and Health Claims
1080 Saint-Louis Road, Sillery
PO Box 1907, Station Terminus
Quebec City, Qc G1K 7M3

Telephone
Quebec City region: (418) 684-5000 ext. 5332
Elsewhere: 1-888-715-5232

ACCIDENT INSURANCE
Accigroup / Accigroup Plus
CLAIMANT'S STATEMENT

INSTRUCTIONS: The claim request, original invoices and other proof must be submitted within **90 days** following the date of the accident. Follow the steps below. Have Step 3 signed by the authorized person from the school or the association. Sign the authorization in Step 6 and send the document to the address above. In all cases involving death, dismemberment or loss of the use, contact your representative or the Company at the number indicated above.

Certain accidents may be covered by a private or government organization such as the WCB, SAAQ, RAMQ, IVAC., etc. You must first submit your claim to this organization and send us a copy of the settlement.

Step 1 CLAIMANT (applicant, father, mother or guardian)

Contract: ☐☐☐☐ Name of group: ______________ Claimant's name: ______________

Address: ____ ☐☐☐ ☐☐☐-☐☐☐☐

Street City Province Postal code Telephone

Step 2 IDENTITY OF THE INJURED PERSON

Name: ______________________ Date of birth: Y ☐ M ☐ D ☐ Sex: ☐ M ☐ F

School attended: ______________________ School board: ______________________

Step 3 DESCRIPTION OF THE ACCIDENT

Place: ______________________ Date: Y ☐ M ☐ D ☐ Time: ______ ☐ a.m. ☐ p.m.

Description: ____

____

Authorized signature from the school or sports association: ______________________

Transportation: Indicate the number of kilometres travelled within 24 hours after the accident: ______________

Step 4 DOCUMENTS REQUIRED FOR DENTAL CARE

Dental care
- Section below to be completed by the dentist
- Dentist's standard dental care form
- Attach X-rays

Dentist's statement

The injuries described above were caused by an accident that took place on: Y ☐ M ☐ D ☐

Name or position of damaged tooth: ______________________

Nature of the injury: ______________________

State of the tooth before the accident (if the tooth was whole and sound). Specify: ______________________

Dentist's name: ______________________ Address: ______________________

Dentist's signature: ______________________

Step 5 DOCUMENTS REQUIRED (The claimant is responsible for securing this form and any charges made for its completion.)

Before submitting a request, check if the benefit and/or the guarantees are included in the contract.

Fracture	• Include a copy of radiologist's report
Physiotherapist / Chiropractor / Other specialist (see policy)	• Original receipt and form provided by the person who gave the treatment
Ambulance	• Original invoice
Other fees	• Attach the original invoice

Step 6 DECLARATION AND AUTHORIZATION

Are the benefits requested covered by another insurance plan? ☐ No ☐ Yes

You must first submit your claim to this insurer and send us a copy of the settlement and attach a copy of the invoice.

Company: ______________________ Contract: ______________________

Name of insured: ______________________ Certificate: ______________________

I hereby certify that the information provided herein is true to the best of my knowledge and that all expenses were incurred by me (or my dependents) for the exclusive use of the above-mentioned person. To evaluate my claim, I authorize any health care professional, health organization or any other public or private organization that has personal information about me or my family to provide this information to Industrial Alliance Insurance and Financial Services Inc. or its authorized representative. A photocopy of this authorization shall be as valid as the original.

Date: ______________ Claimant's signature: ______________________ SIN: ☐☐☐ ☐☐☐ ☐☐☐