INDUSTRIAL ALLIANCE
INSURANCE AND FINANCIAL SERVICES INC.

CLAIMANT'S STATEMENT

Life and Health Claims
1080 Grande Allée West
PO Box 1907, Station Terminus
Quebec City, QC G1K 7M3

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

The claimant is responsible for securing this form and any charges made for its completion.

INSTRUCTIONS: The claimant's statement, original invoices and other proof must be submitted within **90 days** following the date of the accident. Follow the steps below, **sign the request and the authorization** and send the documents to the address above. In all cases involving death, dismemberment or loss of use and disability, contact your agent or the Company at the phone number indicated above.
Certain accidents may be covered by a private or government organization such as the WCB, SAAQ, RAMQ or IVAC. 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: _____ 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.

How did the accident occur? _____

_____

_____

Emergency 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: _____

Specify the state of the tooth before the accident (i.e., if the tooth was whole and sound): _____

Dentist's name: _____ Address _____

Dentist's signature _____

Step 5 DOCUMENTS REQUIRED

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

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

Step 6 DECLARATION AND AUTHORIZATION

Are the benefits requested covered by another insurance plan (employer or other insurance)? ☐ No

If ☐ Yes

You must first submit your claim to this insurer then 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 benefit of the above-mentioned person. To evaluate my claim, I authorize any healthcare 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: _____