INDUSTRIAL ALLIANCE
INSURANCE AND FINANCIAL SERVICES INC.

www.inalco.com

STUDENT GROUP ACCIDENT INSURANCE PLAN – 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

For rapid processing of your request, please send the duly completed form. It will be returned to you if any information is missing.

INSTRUCTIONS: The claim form, original invoices and other proof must be submitted within 90 days following the date of the accident. Follow the steps below. The claimant must have Step 3 signed by the university's authorized representative. Sign the authorization in Step 6 and mail the documents to the address indicated above. In all cases involving death, dismemberment or loss of use and disability, contact the Company at the numbers indicated above.

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

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

Contract no.: ☐☐☐☐ ☐ Undergrad ☐ Grad/Postgrad

University: _____

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

Step 3 DESCRIPTION OF THE ACCIDENT AND RESULTING INJURIES

Date of the accident: Y ☐☐☐☐ M ☐☐ D ☐☐ Is the accident the result of playing in an elite sport activity? ☐ Yes ☐ No

Attach the accident report or personal summary (place, injury) (Add a dated and signed sheet if needed).

_____

_____

Signature of the authorized representative of the university: _____

Transportation: Indicate the number of kilometres travelled in the 24 hours following the accident: _____

Step 4 DOCUMENTS REQUIRED FOR DENTAL CARE (To be completed by the dentist)

Documents required: • Attach X-rays • Dentist's standard dental care form

Dentist's statement

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

Name or position of the tooth damaged during the accident: _____

Nature of the injury: _____

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

Dentist's name: _____ Dentist's address: _____

Dentist's signature: _____

Step 5 DOCUMENTS REQUIRED (The claimant is responsible for having the required forms completed at their own expense.)

Before submitting a claim, verify that the benefit and/or the protection are covered under the contract.

Fracture	➡ Radiologist's report
Physiotherapist/Chiropractor/Other specialists (See policy.)	➡ Original receipts and form provided by the person who administered the treatment
Transportation by ambulance	➡ Complete original invoice
Other fees	➡ Original invoice

Step 6 DECLARATION AND AUTHORIZATION

Are you covered by another insurance plan (employer or other insurance)? ☐ Yes ☐ No

The claim must be submitted to the company offering the insurance first, and a copy of the settlement must be forwarded to us along with copies of the invoices.

Company: _____ Contract No: _____

Name of insured: _____ Certificate No: _____

Are the benefits under this claim covered by this insurance? ☐ Yes ☐ No

I hereby certify that all of 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 aforementioned 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 disclose 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: _____