INDUSTRIAL ALLIANCE
INSURANCE AND FINANCIAL SERVICES INC.

www.inalco.com

GROUP INSURANCE

According to 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

Ontario, Atlantic and Western Provinces
Group Health and Dental Claims
PO Box 4643, Station A
Toronto, Ontario M5W 5E3

CLAIM FORM
MEDICAL EXPENSES – HSA

Please print in ink and sign.

MEMBER INFORMATION

Policyholder's name ____________________ **Policy no.** ______

Member's last name ____________________ First name ____________________

Certificate no. ____________________ Date of birth Y ____ M ____ D ____

Sex: ❑ Male ❑ Female

Language: ❑ English ❑ French

1. COORDINATION OF BENEFITS

- If one of your dependents is covered under another plan for medical expense benefit, the expenses incurred by this dependent must first be submitted to the other insurer. You may subsequently submit a claim for the balance, if applicable, under your plan.
- The expenses incurred by insured dependent children must be submitted to the plan of the parent whose birthday comes first during a calendar year.

Are you or your dependents covered by another group plan? ❑ **No** ❑ **Yes** **If yes, specify:**

Name of insurance company ____________________ Policy no. ____________________

Health Coverage: ❑ Individual ❑ Family

Name of Spouse or Child ____________________ Date of birth Y ____ M ____ D ____

2. MEDICAL EXPENSES *(Attach the original invoices and keep a copy for the coordination of benefits and income taxes.)*

***Health Spending Account (HSA)**

Do you wish the unpaid portion of any expense provided for under the group policy to be paid under your HSA? ❑ Yes ❑ No

If yes, please indicate which expenses you wish to have the unpaid portion paid under your HSA by checking off the box in the HSA column.

All healthcare expenses which are not provided for under your group policy may be paid under your HSA.

Note: If the person for whom the claim is applicable has coverage under another plan, you must first submit the expenses to the other carrier before requesting payment under your HSA.

Name (Member or insured dependent)	**Relationship to member**	**Date of birth** Y M D	**Handicapped child**	**Children 18 and over**		**Amount**	**HSA***
				Full-time student	**Name of school**		
			❑ Yes ❑ No	❑ Yes ❑ No		$	❑
			❑ Yes ❑ No	❑ Yes ❑ No		$	❑
			❑ Yes ❑ No	❑ Yes ❑ No		$	❑
			❑ Yes ❑ No	❑ Yes ❑ No		$	❑
			❑ Yes ❑ No	❑ Yes ❑ No		$	❑
			❑ Yes ❑ No	❑ Yes ❑ No		$	❑
			❑ Yes ❑ No	❑ Yes ❑ No		$	❑
					Total	$	

If there are expenses for the rental or purchase of an appliance, please attach a letter from your physician describing the diagnosis.

If the claim is the result of an accident, specify type of accident: ❑ Work ❑ Motor vehicle ❑ Crime victim ❑ Other ____________________

Date of accident Y ____ M ____ D ____ Place of accident ____________________

CONTINUED ON THE NEXT PAGE

2. MEDICAL EXPENSES (CONT.)

AMBULANCE TRANSPORTATION FEES *(Enclose the receipt from the ambulance service)*

Reason for ambulance service ____________________

Place of pick-up: ❑ Home ❑ Work ❑ Other Specify: ____________________

EXPENSES INCURRED OUTSIDE THE PROVINCE OF RESIDENCE

If the medical expenses were incurred outside the province of residence, please complete F54-371A - MEDICAL EXPENSES INCURRED OUTSIDE THE PROVINCE OF RESIDENCE. To obtain a copy of this form, please call 514 499-3747 or 1 800 203-9024 if you are calling from outside the Montreal area.

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 expenses were incurred by myself or by one of my dependents and are required in connection with the treatment of a medical condition;
3. 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; and
4. that if the claim is being made under my Health Spending Account
   (i) that the expenses are not eligible for reimbursement under the group policy with Industrial Alliance or any other plan;
   (ii) the expenses being claimed qualify for reimbursement under my Health Spending Account;
   (iii) that I understand that any expenses for which I am reimbursed under my Health Spending Account cannot be claimed for income tax purposes and should any tax consequences arise from the reimbursement of these expenses, I am responsible for payment of such taxes.

On behalf of myself and my dependents:

1. **I CONSENT TO THE RELEASE** of the information contained in this claim form to Industrial Alliance, its employees, agents, reinsurers and service providers for the purposes of underwriting, administration and processing of the claim; and
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 Industrial Alliance, 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, Industrial Alliance 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 AUTHORIZE Industrial Alliance to release to my employer/policyholder the amount of my account balance under the Health Spending Account when required for the provision/management of the Health Spending Account.

I AUTHORIZE the use of my Social Insurance Number as an identification number when it is required for the administration of the group policy.

I AGREE that a photocopy of this Confirmation/Authorization shall be as valid as the original.

Member's signature X ____________________ **Date** Y M D

Address ____________________ Postal code

Tel. home Tel. work Extension

YOUR HEALTH SPENDING ACCOUNT

ADDITIONAL INFORMATION

What expenses qualify for reimbursement

1. All expenses that qualify for the medical expense tax credit under the *Income Tax Act* are eligible. These may include expenses not covered by your heath or dental coverage (if any) under the group policy with Industrial Alliance.
2. Expenses which have been paid (or are eligible to be paid) by any other plan (including individual and government plans) do not qualify for reimbursement.

Filing a claim

1. The Health Spending Account is only to be used for expenses or a portion of the expenses which are not covered elsewhere. As a result when claiming:
   (a) for expenses of which a portion is payable under the group policy with Industrial Alliance, you must submit the claim under the policy at the same time you submit it under your Health Spending Account; or
   (b) any expenses of which a portion is payable under a plan other than the group policy with Industrial Alliance, you must first submit the claim under such plan. After a benefit has been paid under the plan, you should then submit the unpaid portion of the claim for payment under your Health Spending Account.
2. Any receipts (copies or originals) which you submit with a claim must include the following information:
   - Name of claimant
   - Nature of the treatment or type of medical product
   - Name of the prescribing physician
   - The date the claim was incurred
   - The amount charged

Before submitting a claim, make sure you have fully completed and signed all forms. Incomplete forms will delay the processing of your claim.