

› Claim Forms


1 - HEALTH INSURANCE

1.1. Medical Expenses (F54-326A)

To request a reimbursement for prescription drugs, medical expenses, paramedical care, vision care or ambulance fees, the member must complete the *Medical Expenses* form (F54-326A) and attach the original receipts.

Drug payment card

If your plan has an ESI drug card, the receipts for prescription drugs are not required if the member presented the drug card to the pharmacist. However, in some cases, the original receipts may be requested.

 INDUSTRIAL ALLIANCE INSURANCE AND FINANCIAL SERVICES INC.	<input type="text"/>	www.inalco.com GROUP INSURANCE
According to your region, please submit form to:		CLAIM FORM MEDICAL EXPENSES
Quebec PO Box 800, Station Maison de la Poste Montreal, Quebec H3B 3K5	Ontario, Atlantic and Western Provinces PO Box 4643, Station A Toronto, Ontario M5W 5E3	
Policy no. <input type="text"/>	Policyholder's name <input type="text"/>	
Member's last name <input type="text"/>	First name <input type="text"/>	
Certificate no. <input type="text"/>	Date of birth <input type="text"/> Y <input type="text"/> M <input type="text"/> D	Sex: <input type="checkbox"/> M <input type="checkbox"/> F Language: <input type="checkbox"/> E <input type="checkbox"/> F
COORDINATION OF BENEFITS		
Are you or your dependent(s) covered by another group plan? <input type="checkbox"/> No <input type="checkbox"/> Yes Specify:		
Name of insurance company <input type="text"/>	Policy no. <input type="text"/>	Coverage: <input type="checkbox"/> Individual <input type="checkbox"/> Family
Name of spouse <input type="text"/>	Date of birth <input type="text"/> Y <input type="text"/> M <input type="text"/> D	

F54-326A


Original receipts

The receipts are not returned.

- › To coordinate benefits with another insurer, the member may include a duplicate or photocopy of the receipts, along with a copy of the benefits statement issued by Industrial Alliance.
- › The member may submit a copy of the benefits statement, for income tax declarations.

1.2. Dental Care in Case of Accident (F54-267A)

To request a reimbursement for Dental Care following accidental injury to natural teeth, the member must send the completed *Dental Care in Case of an Accident* form (F54-267A) and attach the x-rays taken after the accident but before the treatment.

 INDUSTRIAL ALLIANCE INSURANCE AND FINANCIAL SERVICES INC.	<input type="text"/>	www.inalco.com GROUP INSURANCE
According to your region, please submit the completed form to:		CLAIM FORM DENTAL CARE IN CASE OF AN ACCIDENT
Quebec PO Box 800, Station Maison de la Poste Montreal, Quebec H3B 3K5	Ontario, Atlantic and Western Provinces PO Box 4643, Station A Toronto, Ontario M5W 5E3	
Policy no. <input type="text"/>	Policyholder's name <input type="text"/>	

F54-267A

3 - SHORT-TERM DISABILITY INCOME BENEFIT

For a short-term disability income benefit request, check off the "Short-term Disability" box under "Type of claim."

3.1. Initial Request


Have the following people complete the *Disability Claim Form – Initial Request* (F54-381A):

- › the policyholder;
- › the member;
- › the attending physician.

The member must sign in ink part 7, "Member Confirmation/Authorization" of the "Member's Statement," as well as the two parts preceding the "Attending Physician's Statement."

The attending physician must complete the section corresponding to the patient's state of health (psychological or physical illness or both).

Do not detach the pages.

 INDUSTRIAL ALLIANCE <small>INSURANCE AND FINANCIAL SERVICES INC.</small>	<div style="border: 1px solid black; width: 100%; height: 15px; margin-bottom: 5px;"></div>	<small>www.inalco.com</small> GROUP INSURANCE DISABILITY CLAIM FORM Initial Request
<small>According to your region, please submit the completed form to:</small>		
Quebec PO Box 800, Station Maison de la Poste Montreal, Quebec H3B 3K5	Ontario and Atlantic Provinces 522 University Avenue, Suite 400 Toronto, Ontario M5G 1Y7	Western Provinces 1055 West Hastings Street, Suite 1130 Vancouver, British Columbia V6E 2E9
Type of claim: Short-Term Disability <input checked="" type="checkbox"/> Long-Term Disability <input type="checkbox"/> Waiver of Premium <input type="checkbox"/>		
POLICYHOLDER'S STATEMENT TO SPEED PROCESSING, PLEASE ANSWER ALL QUESTIONS. PLEASE PRINT.		
Policyholder's name _____ Address _____ Postal code Telephone E-mail _____ Authorized person's name _____		
PART 1 – MEMBER INFORMATION		
1. Member's name _____ 2. Policy no. Division no. Class no. Certificate no.		

F54-381A

MEMBER'S STATEMENT <small>TO SPEED PROCESSING, PLEASE ANSWER ALL QUESTIONS AND OBTAIN ALL REQUIRED SIGNATURES.</small>
PART 1 – IDENTIFICATION
Last name _____ First name _____ Sex Female <input type="checkbox"/> Male <input type="checkbox"/> Policy no. Social Insurance Number Certificate no. Date of birth Occupation _____ Language French <input type="checkbox"/> English <input type="checkbox"/>
PART 2 – REASON FOR THE CLAIM
1. Accident. If the sick leave was the result of an accident, indicate: - Place of the accident: Home <input type="checkbox"/> Work <input type="checkbox"/> Elsewhere <input type="checkbox"/> (specify) _____ - Date of the accident Circumstances _____ - If a car accident, specify whether you were: the driver <input type="checkbox"/> a passenger <input type="checkbox"/> . If not a Quebec resident, please submit the police report.
2. Is the period of disability due to work-related problems? No <input type="checkbox"/> Yes <input type="checkbox"/> Specify _____

F54-381A

ATTENDING PHYSICIAN'S STATEMENT – PHYSICAL ILLNESS <small>Please print and give to the patient</small> PLEASE ANSWER ALL QUESTIONS AND ATTACH ANY DOCUMENTS PERTINENT TO THE ANALYSIS OF THE REQUEST
PART 1 – DIAGNOSIS
1. Primary: _____ 2. Secondary: _____ 3. Complications: _____ 4. For the illnesses or associated symptoms diagnosed, has the patient previously: received medical treatments <input type="checkbox"/> consulted another physician <input type="checkbox"/> taken medication <input type="checkbox"/> been hospitalized <input type="checkbox"/> undergone examinations <input type="checkbox"/> Specify the periods: _____ 5. a) Is the disability related to the specific risks of this patient's job? No <input type="checkbox"/> Yes <input type="checkbox"/> If so, explain: _____ b) Is the disability related to: an accident <input type="checkbox"/> an illness <input type="checkbox"/> a work accident <input type="checkbox"/> an occupational illness <input type="checkbox"/>

F54-381A


3.2. Extension of disability

If the disability continues beyond the date specified in the initial request, have the *Disability Claim Form – Extension of Disability* (F54-382A) completed by the member or attending physician or provide the information requested by the insurer.

The member must sign in ink part 4, “Member Confirmation/Authorization” of the “Member’s Statement,” as well as the two parts preceding the “Attending Physician’s Statement.”

The attending physician must complete the section corresponding to the patient’s state of health (psychological or physical illness or both).

Do not detach the pages.



INDUSTRIAL ALLIANCE
INSURANCE AND FINANCIAL SERVICES INC.

www.inalco.com

GROUP INSURANCE

DISABILITY CLAIM FORM
Extension of Disability

According to your region, please submit the completed form to:

<p>Quebec PO Box 800, Station Maison de la Poste Montreal, Quebec H3B 3K5</p>	<p>Ontario and Atlantic Provinces 522 University Avenue, Suite 400 Toronto, Ontario M5G 1Y7</p>	<p>Western Provinces 1055 West Hastings Street, Suite 1130 Vancouver, British Columbia V6E 2E9</p>
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Type of claim: Short-Term Disability Long-Term Disability Waiver of Premium

MEMBER'S STATEMENT
TO SPEED PROCESSING, PLEASE ANSWER ALL QUESTIONS AND OBTAIN ALL REQUIRED SIGNATURES.

Please complete and return this form before Y M D

PART 1 – IDENTIFICATION

Last name First name Sex Female Male

Policy no. Social Insurance Number Certificate no.

Date of birth Y M D Occupation Language French English

F54-382A

ATTENDING PHYSICIAN'S STATEMENT – PSYCHOLOGICAL ILLNESS
Please print and give to the patient.
PLEASE ANSWER ALL QUESTIONS AND ATTACH ANY DOCUMENTS PERTINENT TO THE ANALYSIS OF THE REQUEST.

PART 1 – DIAGNOSIS

1. DSM-IV DIAGNOSIS

1.1. (Axis I) Psychiatric disorder: _____


1.2. Please describe the signs and symptoms, indicating the frequency and the degree of severity of each one:
(M= Mild Md= Moderate S= Severe)

Signs	M	Md	S	Symptoms	M	Md	S
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

F54-382A

3.3. Return to work

The employer must confirm the member’s return to work by using the *Notice of Return to Work* form (F54-268A) and specify if it is a full-time, part-time or a gradual return by checking the appropriate box.



INDUSTRIAL ALLIANCE
INSURANCE AND FINANCIAL SERVICES INC.

GROUP INSURANCE

NOTICE OF RETURN TO WORK

According to your region, please submit completed form to:

<p>Quebec PO Box 800, Station Maison de la Poste Montreal, Quebec H3B 3K5</p>	<p>Ontario, Atlantic and Western Provinces 522 University Avenue, Suite 400 Toronto, Ontario M5G 1Y7</p>	
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Last and first name of member (print in ink)

No. Street Apartment

City Postal Code

Policy Number Div.

Certificate Number

F54-268A

MEMBER'S STATEMENT			
TO SPEED PROCESSING, PLEASE ANSWER ALL QUESTIONS AND OBTAIN ALL REQUIRED SIGNATURES.			
PART 1 – IDENTIFICATION			
Last name	First name	Sex Female <input type="checkbox"/> Male <input type="checkbox"/>	
Policy no.	Social Insurance Number	Certificate no.	
Date of birth	Occupation	Language French <input type="checkbox"/> English <input type="checkbox"/>	
PART 2 – REASON FOR THE CLAIM			
1. Accident. If the sick leave was the result of an accident, indicate:			
- Place of the accident: Home <input type="checkbox"/> Work <input type="checkbox"/> Elsewhere <input type="checkbox"/> (specify) _____			
- Date of the accident			
Y	M	D	Circumstances _____
- If a car accident, specify whether you were: the driver <input type="checkbox"/> a passenger <input type="checkbox"/> . If not a Quebec resident, please submit the police report.			
2. Is the period of disability due to work-related problems? No <input type="checkbox"/> Yes <input type="checkbox"/> Specify _____			

F54-381A

ATTENDING PHYSICIAN'S STATEMENT – PSYCHOLOGICAL ILLNESS	
Please print and give to the patient	
PLEASE ANSWER ALL QUESTIONS AND ATTACH ANY DOCUMENTS PERTINENT TO THE ANALYSIS OF THE REQUEST	
PART 1 – DIAGNOSIS	
1. Primary diagnosis: (Axis I) _____	
2. Secondary: (Axis II, III) Personality disorders and other medical conditions. _____	
3. Among the current symptoms, please identify the ones that you observed during office visits. _____	
4. Degree of severity of all symptoms: Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe with psychotic elements <input type="checkbox"/>	
5. Does the interruption of work result from problems related to:	
marital/family life <input type="checkbox"/>	loss of employment or layoff <input type="checkbox"/> alcohol or drug abuse and/or gambling problems <input type="checkbox"/>
personal or interpersonal problems <input type="checkbox"/>	professional problems <input type="checkbox"/>
other problems <input type="checkbox"/> (specify) _____	

F54-381A

4.2. Extension of Disability

If the disability continues beyond the date specified in the initial request, have the *Disability Claim Form – Extension of Disability* (F54-382A) completed by the member or attending physician or provide the information requested by the insurer.

The member must sign in ink part 4, “Member Confirmation/Authorization” of the “Member’s Statement,” as well as the two parts preceding the “Attending Physician’s Statement.”

The attending physician must complete the section corresponding to the patient’s state of health (psychological or physical illness or both).

Do not detach the pages.

 INDUSTRIAL ALLIANCE INSURANCE AND FINANCIAL SERVICES INC.	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>				www.inalco.com GROUP INSURANCE
	DISABILITY CLAIM FORM Extension of Disability				
According to your region, please submit the completed form to: Quebec PO Box 800, Station Maison de la Poste Montreal, Quebec H3B 3K5 Ontario and Atlantic Provinces 522 University Avenue, Suite 400 Toronto, Ontario M5G 1Y7 Western Provinces 1055 West Hastings Street, Suite 1130 Vancouver, British Columbia V6E 2E9					
Type of claim: Short-Term Disability <input type="checkbox"/> Long-Term Disability <input checked="" type="checkbox"/> Waiver of Premium <input type="checkbox"/>					
MEMBER'S STATEMENT TO SPEED PROCESSING, PLEASE ANSWER ALL QUESTIONS AND OBTAIN ALL REQUIRED SIGNATURES.					
Please complete and return this form before <input type="text"/> Y <input type="text"/> M <input type="text"/> D					
PART 1 – IDENTIFICATION					
Last name <input type="text"/>		First name <input type="text"/>		Sex Female <input type="checkbox"/> Male <input type="checkbox"/>	
Policy no. <input type="text"/>	Social Insurance Number <input type="text"/>	Certificate no. <input type="text"/>			
Date of birth <input type="text"/> Y <input type="text"/> M <input type="text"/> D	Occupation <input type="text"/>	Language French <input type="checkbox"/> English <input type="checkbox"/>			


F54-382A

ATTENDING PHYSICIAN'S STATEMENT – PHYSICAL ILLNESS Please print and give to the patient. PLEASE ANSWER ALL QUESTIONS AND ATTACH ANY DOCUMENTS PERTINENT TO THE ANALYSIS OF THE REQUEST.	
PART 1 – DIAGNOSIS	
1.1. Primary: <input type="text"/>	
1.2. Secondary: <input type="text"/>	
1.3. Objective tests performed as part of the physical examination/investigation:	
<input type="checkbox"/> Scan <input type="checkbox"/> MRI <input type="checkbox"/> ECG <input type="checkbox"/> Other tests/investigations performed: <input type="text"/>	
(Please attach copies of the recent test results.)	
Please indicate whether the patient is <input type="checkbox"/> Right-handed or <input type="checkbox"/> Left-handed	

F54-382A

4.3. Return to work

The employer must confirm the member’s return to work by using the *Notice of Return to Work* form (F54-268A) and specify if it is a full-time, part-time or a gradual return by checking the appropriate box.

 INDUSTRIAL ALLIANCE INSURANCE AND FINANCIAL SERVICES INC.	www.inalco.com GROUP INSURANCE			
	NOTICE OF RETURN TO WORK			
According to your region, please submit completed form to: Quebec PO Box 800, Station Maison de la Poste Montreal, Quebec H3B 3K5 Ontario, Atlantic and Western Provinces 522 University Avenue, Suite 400 Toronto, Ontario M5G 1Y7				
Last and first name of member (print in ink) <input type="text"/>			Policy Number <input type="text"/>	Div. <input type="text"/>
No. <input type="text"/>	Street <input type="text"/>	Apartment <input type="text"/>	Certificate Number <input type="text"/>	
City <input type="text"/>		Postal Code <input type="text"/>		

F54-268A

5 - WAIVER OF PREMIUMS

For a waiver of premiums request, check off the "Waiver of Premiums" box under "Type of claim."

Premium payments for certain benefits for the disabled employee and his/her dependents could be waived if included in your contract.

5.1. Initial request

Plans WITHOUT the Long-Term Disability Income Benefit

After a continuous period of disability defined in the contract (generally 6 months), the employer must complete the *Disability Claim Form – Initial Request* (F54-381A).

The following people must also complete the form:

- › the member;
- › the attending physician.

The member must sign in ink part 7, "Member Confirmation/Authorization" of the "Member's Statement," as well as the two parts preceding the "Attending Physician's Statement."

The attending physician must complete the section corresponding to the patient's state of health (psychological or physical illness or both).

The request must be submitted 3 months after the onset of disability at the earliest, and 6 months after the onset of disability at the latest.

Plans WITH the Long-Term Disability Income Benefit

The waiver of premiums takes effect as soon as the long-term disability income insurance benefits are paid, unless your contract provides for a different period.

Employee Eligible for Disability Benefits from a Government Plan other than the QPP/ CPP (Eg.: WSIB, WCB, CSST, SAAQ, IVAQ)

Even if the member is eligible for benefits from a government plan that covers disabilities following an accident at work, an automobile accident or a criminal act, a Waiver of Premium request must be submitted to Industrial Alliance.

The employer must complete the "Policyholder's statement" section of the *Disability Claim Form – Initial Request* (F54-381A).

The following people must also complete the form:

- › the member;
- › the attending physician.

In addition, the member must:

- › sign in ink part 7, "Member Confirmation/Authorization" of the "Member's Statement," as well as the two parts preceding the "Attending Physician's Statement;"
- › attach a photocopy of the benefits statement from a government plan other than QPP/ CPP (Eg.: WSIB, WCB, CSST, SAAQ, IVAQ);
- › attach a copy of all communications received from the government plan mentioned previously (for example, a letter of approval and proof of payment) and if possible, a copy of the file.

The attending physician must complete the section corresponding to the patient's state of health (psychological or physical illness or both).

The request must be submitted 3 months after the onset of the disability at the earliest, and 6 months after the onset of the disability at the latest.

Do not detach the pages.

5.2. Extension of disability

If the disability continues beyond the date specified in the initial request, have the *Disability Claim Form – Extension of Disability* (F54-382A) completed by the member or attending physician or provide the information requested by the insurer.

The member must sign in ink part 4, "Member Confirmation/Authorization" of the "Member's Statement," as well as the two parts preceding the "Attending Physician's Statement."

The attending physician must complete the section corresponding to the patient's state of health (psychological or physical illness or both).

Do not detach the pages.

