INDUSTRIAL ALLIANCE
INSURANCE AND FINANCIAL SERVICES INC.

www.inalco.com

GROUP INSURANCE

CLAIM FORM
MEDICAL EXPENSES

According to your region, please submit complete form to:
Ontario, Atlantic and Western Provinces
PO Box 4643, Station A
Toronto, Ontario M5W 5E3

Policyholder's name MEMORIAL UNIVERSITY OF NEWFOUNDLAND STUDENTS' UNION

Policy no. 2 4 1 1 4 Division no. _____ Class no. _____

Member's last name _____ First name _____

Certificate no. _____ Date of birth Y M D _____ Sex: ❑ M ❑ F Language: ❑ E ❑ F

ASSIGNMENT OF BENEFITS

Provider: _____
Name Address Postal code

I hereby assign my benefits payable from this claim to the named provider and authorize payment directly to him.

_____ _____
Member's signature Date

COORDINATION OF BENEFITS

Are you or your dependent covered by another group plan? ❑ No ❑ Yes Specify:

Name of insurance company _____ Policy no. _____ Coverage: ❑ Individual ❑ Family

Name of spouse _____ Date of birth Y M D _____

MEDICAL EXPENSES

(Attach the original receipts and keep a copy for income tax purposes and the coordination of benefits. If there are three originals, please enclose Original 1.) ***The receipts will not be returned and they will be destroyed 60 days after receipt.***

NAME (member or insured dependent)	RELATIONSHIP TO THE MEMBER	DATE OF BIRTH Y M D	18 and over Full-time student No Yes	Handicapped child No Yes	CHILDREN 18 AND OVER Name of school	TOTAL
			❑ ❑	❑ ❑		$
			❑ ❑	❑ ❑		$
			❑ ❑	❑ ❑		$
			❑ ❑	❑ ❑		$

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

Expenses following an accident? ❑ No ❑ Yes Nature of accident: ❑ Work ❑ Motor vehicle ❑ Crime victim ❑ Other _____

Date of accident Y M D _____ Place of accident _____

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 "MEDICAL EXPENSES INCURRED OUTSIDE THE PROVINCE OF RESIDENCE" (F54-371A). 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.

MEMBER CONFIRMATION/AUTHORIZATION

Y M D

I HEREBY CONFIRM that the information contained in this Claim Form is true and complete to the best of my knowledge.

I HEREBY CONFIRM that the expenses were incurred by myself or by one of my insured dependents and are required in connection with the treatment of a medical condition.

If this claim is being made on behalf of my spouse and or/dependent children, **I CONFIRM that I am AUTHORIZED** to disclose information about them with respect to this claim.

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, public or private organization or institution to disclose to Industrial Alliance, its employees, agents and service providers any information regarding the treatment and charges incurred which they may need in the assessment of the claim.

I AUTHORIZE the use of my Social Insurance Number as an identification number where 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 _____

Address _____ Postal code _____

Tel. home ( ) _____ Tel. work ( ) _____