

Depending on 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 **Estimate**

1. PRIMARY MEMBER INFORMATION

Member's last name _____ First name _____

Group policy no. _____ Certificate no. _____ Company/Association name _____

Date of birth

Y	M	D

 Sex: M F Language: English French

Preferred method of contact for the purpose of claims resolution:

Telephone _____ Email address _____

Complete this section only if your information has recently changed.

Member's address _____ Postal code _____

2. COORDINATION OF BENEFITS (Complete this section only if your spouse or dependent children are covered by another group plan.)

- If your spouse or dependent children are covered under their own group plan for medical or dental benefits, the claim must first be submitted to his/her group insurance carrier. You may subsequently submit a claim to Industrial Alliance Insurance and Financial Services Inc. for the unpaid portion, if applicable. **Your Health Spending Account can be used to reimburse fees only after the coordination of benefits has been considered, if applicable.**
- If your insured dependent children are covered under your plan as well as under your spouse's group plan, the claim must be submitted to the plan of the parent whose birthday comes first during a calendar year.

Is your spouse or dependent child(ren) covered by another group plan for medical or dental benefits? No Yes, please complete the information below.

Benefit types: Medical Dental Both Coverage: Individual Family

Name of insured spouse/child _____ Date of birth

Y	M	D

Are you claiming any expenses for your spouse or dependent children that are **NOT** covered under their plan?

No Yes, please specify the benefit: _____

If your spouse's group insurance carrier is also Industrial Alliance Insurance and Financial Services Inc., do you want us to apply coordination of benefits?

No Yes, please specify: Spouse's group policy no. _____ Certificate no. _____

3. EXPENSES TO BE REIMBURSED

- For medical expenses, attach the original receipts. For dental care, attach the dentist's form. In both cases, you must also attach a copy of the explanation of benefits from the other group insurance carrier if Industrial Alliance Insurance and Financial Services Inc. is not the primary insurer. Keep a copy of the receipts for the coordination of benefits and income tax purposes. The receipts will not be returned to you, and they will be destroyed 60 days after receipt.

***Health Spending Account (HSA)**

Please indicate which expenses you wish to have the unpaid portion paid under your HSA by checking yes or no in the HSA column for each expense. Medical and dental expenses which are not covered or only partially covered under your group policy may be considered under your HSA as outlined by the Income Tax Act.

Name (One line per claimant)	Relationship to member	Date of birth Y M D	Children 18 and over (or according to your plan)						Total expenses (Per claimant)	HSA*	
			Handicapped child		Full-time student		Name of school	Yes		No	
			Yes	No	Yes	No					
			<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"/>	
			<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"/>	

If the medical claim is the result of an accident, please specify type of accident (details on reverse side, if applicable): Work Motor vehicle

Date of accident

Y	M	D

 Other _____

If the dental claim is the result of an accident, please complete the *Claim Form – Dental Care in case of an accident (F54-267A)*, which can be found on our website.

Continued on the next page

