INDUSTRIAL ALLIANCE ℠
INSURANCE AND FINANCIAL SERVICES

PO Box 790, Station B, Montreal, Quebec H3B 3K6

CLAIM REQUEST • MEDICAL EXPENSES

Policy no. ____ Division no. ____ Certificate no. ____

Employee's surname _____ Given name _____

Address _____
No. Street Apt.

_____ Postal code ____
City Province

Date of birth Y M D ____ Sex: ❑ M ❑ F Language: ❑ E ❑ F

EMPLOYEE'S STATEMENT

COORDINATION OF BENEFITS

IMPORTANT NOTE:

Under the coordination of benefits clause of your plan, if your spouse participates in a medical expenses reimbursement program, the medical expenses incurred by your spouse must first be submitted to his (her) insurer. You may subsequently submit a request for the balance, if applicable.

The expenses incurred by insured dependent children must be submitted to the plan of the parent whose birthday comes first during a calendar year.

Is your spouse, if any, covered by an another group plan? ❑ No ❑ Yes, specify:

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

Name of Spouse _____ Date of birth Y M D ____

INSTRUCTIONS

Attach the original receipts and keep a copy for income tax purposes and the coordination of benefits. The receipts will not be returned and they will be destroyed 60 days after receipt.

For faster service, avoid the peak periods of December, January and June. If possible, wait until expenses incurred reach at least $50 before submitting a claim.

MEDICAL EXPENSES *(Enclose original of invoices or detailed receipts)*

❑ Medication ❑ Hospitalization ❑ Ambulance ❑ Paramedical care ❑ Vision care ❑ Orthopedic shoes ❑ Other expenses

EMPLOYEE	SPOUSE	CHILDREN	SEX M	SEX F	18 AND OVER student no	18 AND OVER student yes	GIVEN NAME	DATE OF BIRTH Y M D	CHILDREN 18 AND OVER Name of school or employer	AMOUNT TOTAL
❑	❑	❑	❑	❑	❑	❑				$
❑	❑	❑	❑	❑	❑	❑				$
❑	❑	❑	❑	❑	❑	❑				$
❑	❑	❑	❑	❑	❑	❑				$

Expenses following an accident? ❑ No ❑ Yes Total $

Nature of accident : ❑ Work ❑ Motorized 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 *(Complete the section above in case of accident)* _____

Place of pick-up: ❑ Home ❑ Work ❑ Other, specify _____

I hereby certify that the information given is true and complete, to the best of my knowledge, and that all expenses were incurred by me or my dependents for the exclusive use of the above-mentioned person.

Signature of employee X _____ Date _____

Address _____ Tel. ( ) ____

_____ Postal code ____ Tel. ( ) ____

FRANÇAIS AU RECTO

℠ Industrial-Alliance Life Insurance Company