INDUSTRIAL ALLIANCE *PACIFIC*™
INSURANCE AND FINANCIAL SERVICES

# Student Union of Confederation College Inc.
# Policy Number – 100003973

***Please print in ink***

## *Claims Procedure*

**REVERSE SIDE MUST BE COMPLETED BY DOCTOR/DENTIST ON ALL INJURY CLAIMS.**

IMPORTANT: Please attach **original receipts** for all eligible expenses. Completed claim form must be filed with IAP within 90 days after the date of the injury, and no later than 1 year, regardless of whether expenses have been incurred. Mail to **IAP, Claims Department, 2165 W Broadway, PO Box 5900, Vancouver, BC, V6B 5H6 Toll Free: 1-800-556-7411**

## *Student Information*

Full Name of Student — Surname | First Name | Initial

Sex: M F

Date of Birth (D D / M M / Y Y Y Y)

Home Address

Street | City | Province | Postal Code

Current Mailing Address (If different from above)

Street | City | Province | Postal Code

Name of Parent or Guardian

Student I.D. Number

## *Accident Information*

Date of Accident (D D / M M / Y Y Y Y)

Time of Accident

A.M. ❑
P.M. ❑

Where did accident occur?

Please explain, **in detail**, how accident happened *(If you require more space attach a seperate sheet of paper, signed and dated):*

What injuries were caused by the accident?

Under whose immediate supervision was student at time of the accident?

## *Treatment Received*

On what date did you first consult Physician or Dentist? (D D / M M / Y Y Y Y)

Name of Physician or Dentist

Address of Physician or Dentist

Are any benefits or services provided under any other group insurance or plan?

Yes ❑ No ❑

Policy Number

Certificate or Identity Number

Name of Insuring Company

## *Authorization and Declaration*

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

On behalf of myself and/or any minor insured, I RELEASE the information contained in this Claim Form to Industrial-Alliance *Pacific* Life Insurance Company ("IAP") and ACKNOWLEDGE that this information will be used to assess, process and administer this claim and policy coverage. I AUTHORIZE any health care provider, insurance company, school or school board, employer, or other person or other organization to disclose to IAP any medical information, information regarding charges, or other information that IAP may need in their assessment of this claim.

I AUTHORIZE IAP to exchange the information detailed in this Claim Form and other information contained in files related to this claim or coverage with any of the parties identified in the previous paragraph for the purposes listed above, or as authorized by me, or as legally required.

Signed: _____
Student (Parent or Guardian if a Minor)

Date Signed (D D / M M / Y Y Y Y)

Telephone #

## *Statement of School Authority*

On the date of the accident, we certify that the above claimant was enrolled as a:

Full time student (3 or more courses) ❑ Part Time student ❑

Signed: _____
Signature of Person Authorized by Policyholder

_____
Title/Name

Date Signed (D D / M M / Y Y Y Y)

**The Claimant is responsible for securing this form and for charges incurred for its completion.**


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## Section A - Attending Physician's Statement

**Physician Information (Print)**

Name

Address

City Province Postal Code

Telephone

**Patient Information (Print)**

Name

Address

City Province Postal Code

Telephone

**1. Diagnosis including complications (If fracture, specify bones and type of fracture)**

**2. Did any disease or previous injury contribute to loss?**

Yes ❑ No ❑ If Yes, describe

**3. To the best of my knowledge**

(a) Symptoms first appeared (D D / M M / Y Y Y Y)

(b) Patient has had same or similar condition Yes ❑ No ❑

(c) If "Yes", state when and describe

**4. Date of first visit for present disability** (D D / M M / Y Y Y Y)

**Date of latest attendance** (D D / M M / Y Y Y Y)

**Date of Surgery** (D D / M M / Y Y Y Y)

**Treatment required**

**5. If referred to you give name of referring Physician**

Physician's Signature (D D / M M / Y Y Y Y)

## Section B – Attending Dentist's Statement

**Dentist Information (Print)**

Name

Address

City Province Postal Code

Telephone

**Patient Information (Print)**

Name

Address

City Province Postal Code

Telephone

| Date of Service Day | Month | Year | Int. Tooth Code | Procedure Code | Tooth Surfaces | Laboratory Charge | Dentist's Fee | Total Charge |
|---|---|---|---|---|---|---|---|---|
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This is an accurate statement of services performed and fees charged. E & OE

TOTAL SUBMITTED FEE ➔

Dentist's Signature Date DD MMM YYYY

For dentist's use only. For addtional information re: diagnosis, procedures, or complications, and special considerations.

I understand that the fees listed in this claim may not be covered by or may exceed my policy benefits. I understand that I am financially responsible to my dentist for the entire cost of the treatment. I authorize release of the information contained in this claim form to my insuring company or its agents. I also authorize the communication of information related to the coverage of services described in this form to the named dentist.

I hereby assign benefits payable from this claim to the above named dentist and authorize payment directly to the dentist.

Signature of patient (or parent/guardian)

Signature of subscriber

**Dentist Supplementary Report (must be completed in full)**

1. Description of damage

2. Teeth injured

3. Is further treatment indicated? No ❑ Yes ❑ If "Yes" please indicate:

| Int.Tooth Code | | Treatment indicated – Use procedure code if possible | Est. Date - Treatment DD | MMM | YYYY |
|---|---|---|---|---|---|
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Dentist's Signature

Date (D D / M M M / Y Y Y Y)