Blanket Student Accident Claims Information Sheet

This document addresses frequently asked questions about Blanket Student Accident Insurance claims.

MEDICAL INJURY CLAIMS

- The Blanket Student Accident Insurance Standard Claim Form must be completed in full in order to process your claim. Please be sure to include the ***Attending Physician's Statement*** section which must be completed by the attending physician (MD) who first saw the insured within 30 days of the injury. Chiropractors, Physiotherapists, Registered Nurses, or any other service providers are **not eligible** to complete the form.
- In the event that the insured was initially seen in a hospital, a copy of the Hospital Admission or Emergency Room Report may be submitted instead of the Attending Physician's Statement. If you are claiming for the expense of an ambulance only, we **do not** require the attending Physician's Statement (nor the Hospital Admissions Report). Submit the original Ambulance invoice together with the top parts of the Student Accident claim form.
- If your policy provides **Physiotherapy coverage,** claims for these items must be accompanied by the original receipts and the written referral from the attending physician recommending physiotherapy treatment.
- If your policy provides coverage for **Brace expenses**, claims for these items must be accompanied by the original receipts and the written referral from the attending physician indicating that the brace is required for therapeutic or curative purposes only.

DENTAL INJURY CLAIMS

- The Blanket Student Accident Insurance Standard Claim Form must be completed in full in order to process your claim. If claiming for dental injury, please be sure that both the ***Part 1 & Part 2 Dentist*** sections on Page 2 of the claim form are completed by the attending dentist who saw the insured within 60 days of the injury.
- If you have more than one insurance carrier, please note that we require a detailed Explanation of Benefits from your primary carrier along with the completed claim form including the specific dental procedure and tooth codes.

IMPORTANT

- The Blanket Student Accident Insurance Standard Claim Form must be filed with Industrial Alliance Insurance and Financial Services Inc. (the "Company"), within 90 days of the date of the injury, regardless of whether expenses have been incurred. Attach only original receipts for all eligible expenses being claimed.
- Please note that it is the responsibility of the Parent/Legal Guardian to obtain and forward the completed claim form as indicated. Any charge incurred for its completion is also the responsibility of the Parent/Legal Guardian.
- If you have more than one insurance carrier, benefits are coordinated. Please submit your expenses to your other insurance company first. Once you have received a copy of the Explanation of Benefits, please forward to the Company with copies of expenses.
- Please note: In providing this claim form for the convenience of the claimant, the Company does not admit any liability or waive any of the terms and conditions of the policy. Provision of this claim form does not indicate coverage. Only eligible claims will be paid.
- If you have any questions regarding coverage, your claim or require additional information, please contact our office at 1-800-266-5667 for instructions and information.

Return completed claim form to:

INDUSTRIAL ALLIANCE INSURANCE AND FINANCIAL SERVICES INC.
Claims Department, 400–988 Broadway W, PO Box 5900, Vancouver, BC, V6B 5H6
Tel: 1-800-266-5667
www.inalco.com

Blanket Student Accident Insurance
Standard Claim Form

It is the responsibility of the parent to obtain and forward the completed claim form as indicated, and for any charge made for its completion.

Please print in ink

Please Tell Us About Yourself

Name of Parent or Legal Guardian (please print)

Last Name | First Name | Initials

Address

City | Province | Postal Code

Telephone (home) | Telephone (work)

Insured's Information (Print)

Last Name | First Name | Initials

Date Of Birth (D D M M M Y Y Y Y)

Sex ❑ Male ❑ Female

Name Of School | Grade/Year

Name Of School Board | Policy #

Please Tell Us About the Accident

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

Time Of Accident (H H M M) ❑ am ❑ pm

Where did the accident occur?

How did the accident happen? (Please provide a detailed explanation)

What injuries were caused by the accident?

On what date was the Physician or Dentist first consulted for this injury?

Name & Address of Dentist or Physician:

Are any other hospital and medical or dental insurance benefits available?

❑ Yes ❑ No

If Yes: Name of other insuring company

1. I hereby CERTIFY that the information contained in this Claim Form is true and complete to the best of my knowledge.
2. On behalf of myself and/or any minor insured, I RELEASE the information contained in this Claim Form to Industrial Alliance Insurance and Financial Services Inc. (the "Company") 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 the Company any medical information, information regarding charges, or other information which the Company may need in their assessment of this claim.
3. I AUTHORIZE the Company 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.

Dated this _____ (DAY) of _____ (MONTH) Year _____ (YEAR (4 DIGITS)) Claimant: _____ *Signature of Parent or Legal Guardian or Insured*

Attending Physician's Statement – (Must be Completed in Full and Signed by the Attending Physician)

Describe condition: _____ due to: Accident ❑ or Illness ❑

Fracture ❑ and/or Location & Type _____

Other Injury ❑ Location & Type _____

Referred for: Physiotherapy ❑ Massage Therapy ❑ ?

Date of onset of symptoms or injury: _____ Did any disease or previous injury contribute to loss? ❑ No ❑ Yes

If Yes, describe: _____ First date treated for this condition _____ (D D / M M M / Y Y Y Y)

Date of surgery _____ (D D / M M M / Y Y Y Y) Under general anaesthetic ❑ or under local anaesthetic ❑ ? Was Claimant hospitalized? ❑ No ❑ Yes

Name of Hospital _____ Date Admitted _____ (D D / M M M / Y Y Y Y)

Hospital Address _____ Date Discharged _____ (D D / M M M / Y Y Y Y)

Date: _____ (D D / M M M / Y Y Y Y) _____ *NAME OF PHYSICIAN (please print)* _____ *Signature of Attending Physician (M.D.)*

Please Return To: Industrial Alliance Insurance and Financial Services Inc., Claims Department, 400 – 988 Broadway W, PO Box 5900, Vancouver, BC V6B 5H6 1-800-266-5667

Important: Completed claim form must be filed with Industrial Alliance Insurance and Financial Services Inc. (the "Company"),within 90 days after the date of the injury, and in no event later than 1 year, regardless of whether expenses have been incurred. Please attach original receipts for all eligible expenses being claimed. It is the entire responsibility of the parent to obtain and forward the completed claim form as indicated, and for any charge made for its completion.

Medical Injury Claims: The physician must complete the Attending Physician's (M.D.) Statement in order to process the claim. If claim involves physiotherapy or massage therapy expenses a copy of the Physician's referral for the therapy must accompany the completed claim form with receipts.

Dental Injury Claims: The reverse side of this form must be completed and signed by the dentist in order to process the claim.

Approved by CANADIAN DENTAL ASSOCIATION

Part 1 – Dentist

Dentist Information

Name

Address

City Province Postal Code

Telephone

Patient Information

Name

Address

City Province Postal Code

Telephone (home) Telephone (work)

Date of service			Int. Tooth Code	Procedure Code	Tooth Surfaces	Laboratory Charge	Dentist's Fee	Total Charge
Day D D	Month M M M	Year Y Y Y Y						

Are any dental benefits provided under any other private or government plan or policy?

❑ No ❑ Yes

If yes, name of Plan/Company

This is an accurate statement of services performed and fees charged E & OE

TOTAL SUBMITTED FEE →

Please do not forward x-rays, study models, or intra-oral photos unless requested by our office.

Dentist's Signature Date Day Month Year

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 the release of the information contained in this claim form to my insuring company or agents. I also authorize the communication of information related to the coverage of services described in this form to the named dentist.

Signature of the Patient (or Parent/Legal Guardian)

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

Signature of subscriber

Part 2 – Supplementary Dental Report (Must be Completed in Full)

1. Description of damage: _____

2. Teeth involved in the Accident: _____

3. Were these teeth whole or sound prior to the accident? No ❑ Yes ❑ If "No" Please indicate: _____

4. Is further treatment indicated? No ❑ Yes ❑ If "No" Please indicate:

Int. Tooth Code	Treatment indicated – Use procedure code if possible	Est. Date – Treatment		
		Day D D	Month M M M	Year Y Y Y Y

5. Describe further potential problems and indicate the time frame: _____

Dated this _____ of _____ Year _____ _____

DAY MONTH YEAR (4 DIGITS) *Dentist's Signature*