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., 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 Industrial Alliance with copies of expenses.

• Please note: In providing this claim form for the convenience of the claimant, Industrial Alliance 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, 2165 Broadway W, PO Box 5900, Vancouver, BC, V6B 5H6

Tel: 1-800-266-5667

www.inalco.com
Please print in ink

**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 Tell Us About Yourself**

<table>
<thead>
<tr>
<th>Name of Parent or Legal Guardian (please print)</th>
<th>Insured's Information (Print)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last Name</td>
<td>Last Name</td>
</tr>
<tr>
<td>First Name</td>
<td>First Name</td>
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<td>Initials</td>
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<tr>
<td>Address</td>
<td>Date Of Birth</td>
</tr>
<tr>
<td>City</td>
<td>Sex</td>
</tr>
<tr>
<td>Province</td>
<td>Male</td>
</tr>
<tr>
<td>Postal Code</td>
<td>Female</td>
</tr>
<tr>
<td>Telephone (home)</td>
<td>Grade/Year</td>
</tr>
<tr>
<td>Telephone (work)</td>
<td>Name Of School</td>
</tr>
<tr>
<td></td>
<td>Name Of School Board</td>
</tr>
<tr>
<td></td>
<td>Policy #</td>
</tr>
</tbody>
</table>

**Please Tell Us About the Accident**

<table>
<thead>
<tr>
<th>Date of Accident</th>
<th>Time Of Accident</th>
<th>On what date was the Physician or Dentist first consulted for this injury?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Name &amp; Address of Dentist or Physician:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Are any other hospital and medical or dental insurance benefits available?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>If Yes: Name of other insuring company</td>
</tr>
</tbody>
</table>

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

Describe condition: ____________________________ due to: Accident ☐ or Illness ☐

Fracture ☐ 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 ____________________________

Date of surgery ____________________________

Under general anaesthetic ☐ or under local anaesthetic ☐?

Was Claimant hospitalized? ☐ No ☐ Yes

Name of Hospital ____________________________

Hospital Address ____________________________

Date: ____________________________

Name Of Physician (please print) ____________________________

Signature of Attending Physician (M.D.) ____________________________

**Please Return To:** Industrial Alliance Insurance and Financial Services Inc., Claims Department, 2165 Broadway W, PO Box 5900, Vancouver, BC V6B 9H6 1-800-266-5667

**Important:** Completed claim form must be filed with Industrial Alliance Insurance and Financial Services Inc., 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.
### Part 1 – Dentist

**Dentist Information**

Name

Address

City Province Postal Code

**Telephone**

**Patient Information**

Name

Address

City Province Postal Code

**Telephone (home) Telephone (work)**

---

<table>
<thead>
<tr>
<th>Date of service</th>
<th>Int. Tooth Code</th>
<th>Procedure Code</th>
<th>Tooth Surfaces</th>
<th>Laboratory Charge</th>
<th>Dentist's Fee</th>
<th>Total Charge</th>
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</thead>
<tbody>
<tr>
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<td>Month</td>
<td>Year</td>
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This is an accurate statement of services performed and fees charged E & OE

TOTAL SUBMITTED FEE

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**Dentist's Signature**

Date Day Month Year

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

- [ ] No
- [x] Yes

If yes, name of Plan/Company

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

---

**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 [x]  If “No” Please indicate: ________________________________________________

4. Is further treatment indicated?  No [ ] Yes [x]  If “No” Please indicate: ________________________________________________

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

---

Approval by

**Int. Tooth Code**  **Treatment indicated – Use procedure code if possible**

<table>
<thead>
<tr>
<th>Int. Tooth Code</th>
<th>Treatment indicated – Use procedure code if possible</th>
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</tbody>
</table>

Est. Date – Treatment

<table>
<thead>
<tr>
<th>Day</th>
<th>Month</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>DD</td>
<td>MMMM</td>
<td>YYYY</td>
</tr>
</tbody>
</table>

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Signature of the Patient (or Parent/Legal Guardian)

Signature of subscriber

---

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

---

Dated this ___ of ___ 20__ Year ___

Dentist’s Signature