INDUSTRIAL ALLIANCE
INSURANCE AND FINANCIAL SERVICES INC.

Life and Health Claims
1080 Grande Allée West
PO Box 1907, Station Terminus
Quebec City, Qc G1K 7M3
Telephone: (418) 684-5232

www.inalco.com

HEALTH MODULES
CLAIMANT'S STATEMENT

IMPORTANT: **FOR DISABILITY INCOME INSURANCE**, complete form F35-55A, which your agent will give to you.
FOR DENTAL INSURANCE, send the form provided by the dentist.

Step 1 IDENTIFICATION

Contract: ____ Applicant's name: _____

Address: _____ ____-____
Street City Province Postal code Telephone

Step 2 DECLARATION

Are the benefits requested covered by another insurance plan?

☐ No ☐ Yes Company: _____ Contract: _____

Insured's name: _____ Certificate: _____

Step 3 BENEFIT — HEALTH INSURANCE

Please indicate the last name, first name, date of birth and the appropriate reimbursement code from the list. If possible, wait until there is a minimum of $50 in fees before making a claim. **Attach the original copy of any receipts or bills** and keep a copy for your files. All receipts become the property of Industrial Alliance and are destroyed 60 days after reception. If the expenses were incurred after an accident, complete the "Accident Report" section.

List of codes

1 Drugs
2 Paramedical fees
3 At-home care
4 Ambulance
5 Hospitalization fees in Canada
6 Emergency care outside of Canada
7 Other fees covered

Date	Insured	Spouse	Child	Last name	First name	Date of birth	Code	Amount
	☐	☐	☐					
	☐	☐	☐					
	☐	☐	☐					
	☐	☐	☐					
	☐	☐	☐					
	☐	☐	☐					
	☐	☐	☐					
	☐	☐	☐					

If you require additional space, see reverse side.

Accident Report

Date of accident: Y M D Location: _____

Type: ☐ Work ☐ Traffic ☐ Criminal act ☐ Other

Description: _____

Ambulance

Attach your original receipts.

Reason for ambulance: _____

Picked up at:
☐ Home ☐ Work ☐ Other _____

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

Date: _____ Claimant's signature: _____ SIN: ____

PLEASE DO NOT DETACH THE AUTHORIZATION

AUTHORIZATION

To assess the present claim, I hereby authorize any health care professional, any health organization or any other public or private organization that has personal information about me or my family, to provide this information to **Industrial Alliance Insurance and Financial Services Inc.** or its authorized representatives. A photocopy of this authorization shall be as valid as the original.

Signed at _____ this _____ day of _____ 20 ____

_____ Witness

_____ Address

Postal code _____ Telephone _____

_____ Insured

_____ Address

Postal code _____ Telephone _____

Step 3 **BENEFIT** **HEALTH INSURANCE (CONT.)**

Date	Insured	Spouse	Child	Last name	First name	Date of birth	Code	Amount
	☐	☐	☐					
	☐	☐	☐					
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