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 Discharge Report* may be submitted instead of the Attending Physician's Statement.
- 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 Pacific Insurance and Financial Services Inc. ("IAP"), 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 IAP with copies of expenses.
- Please note: In providing this claim form for the convenience of the claimant, IAP 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 1-800-556-7411 for instructions and information.

Return completed claim form to:
INDUSTRIAL ALLIANCE PACIFIC INSURANCE AND FINANCIAL SERVICES INC.
Claims Department, 2165 Broadway W, PO Box 5900, Vancouver, BC, V6B 5H6
Tel: 1-800-566-7411
www.iapacific.com

™ Trademark of Industrial Alliance Insurance and Financial Services Inc., used under license by Industrial Alliance Pacific Insurance and Financial Services Inc..

Blanket Student Accident Insurance Standard Claim Form

Please print in ink

Please Tell Us About Yourself

Name of Parent or Legal Guardian (please print)

Name

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 priovide a detailed explaination)

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 Pacific Insurance and Finacial Services Inc. ("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 which IAP may need in their assessment of this claim.
3. 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.

Dated this ________ of ______________________ Year _________ Claimant: ______________________________
DAY | MONTH | YEAR (4 DIGITS) | *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 ❑ Location & Type ______________________________
and/or
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 Pacific Insurance and Financial Services Inc., Claims Department, 2165 Broadway W, PO Box 5900, Vancouver, BC V6B 5H6 1-800-556-7411

Important: Completed claim form must be filed with Industrial Alliance Pacific 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.

™ Trademark of Industrial Alliance Insurance and Financial Services Inc., used under license by Industrial Alliance Pacific Insurance and Financial Services Inc.

Approved by CANADIAN DENTAL ASSOCIATION

Part 1 – Dentist

Dentist Information

Name

Address

City | Province | Postal Code

TelephonePatient

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						

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

TOTAL SUBMITTED FEE ➔

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

❑ No ❑ Yes

If yes, name of Plan/Company

___

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