



Camper's Claims Information Sheet

This document addresses frequently asked questions related to Camper Insurance claims

MEDICAL INJURY CLAIMS

- The Camper's Claim Form must be completed in full in order to process your claim. Please be sure to include the **Section A-Attending Physician's Statement** section on Page 2 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.
- Claims for **Physiotherapy/ Athletic Therapy / Brace expenses** must be accompanied by the original receipts and the written referral from the attending physician recommending the treatment.

DENTAL INJURY CLAIMS

- The Camper's Claim Form must be completed in full in order to process your claim. If claiming for dental injury, please be sure that Page 1 and **Section B-Attending Dentist's Statement** on Page 2 of the claim form are completed by the attending dentist who saw the insured within 30 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 bottom of the claim form must also be **SIGNED & AUTHORIZED** by the **Camp Director ONLY**. The claim cannot be processed in the absence of this authorization.
- The Camper's 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 expenses being claimed.
- Please note that it is the responsibility of the claimant to obtain and forward the completed claim form as indicated. Any charge incurred for its completion is also the responsibility of the claimant.
- If you have more than one insurance carrier, medical expense 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.

WHAT TO EXPECT WHEN YOUR CLAIM IS RECEIVED.....

- Please note that all claims are subject to standard adjudication processing. You should expect a response within 1-3 weeks depending on claims volume. Our response would be one of the following:

(A) *Payment or Notification of Payment to a Provider*

(B) *Request for more information if required*

(C) *Acceptance or Denial of the claim with reasons*

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: 1-800-266-5667
www.iapacific.com

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.



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Claims Procedure

NOTE: PLEASE HAVE REVERSE OF FORM COMPLETED BY DENTIST AND/OR DOCTOR

Important – This form should be completed and mailed immediately (or as soon as possible thereafter) to: Industrial Alliance Pacific Insurance and Financial Services Inc., Claims Department, 2165 W Broadway, P.O. Box 5900, Vancouver, BC, V6B 5H6 together with fully itemized original bills. Ph: 1-800-266-5667

Note 1 – If the claim is for dental injury, have Section 'B' on the back of the form completed by the Dentist.

Note 2 – If the claim is for other injury/sickness, have Section 'A' on the back of the form completed by the Doctor.

Note 3 – The Insured is responsible for securing the information and for any charge incurred for its completion.

Camp/Camper Information

Name of Camp	Name of Policyholder	Policy Number
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Address of Camp	City	Province	Postal Code
Street			

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

Address of Camper	City	Province	Postal Code
Street			

Name of Parent or Guardian

Accident

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

Circumstances under which accident occurred

Sickness

Date of Onset	Diagnosis
(D D / M M / Y Y Y Y)	

Treatment Received

Name and Address of Doctor(s) seen:

If Treated in a Hospital, Give Name and Address

Dates of Treatment

Are benefits for accidents or sickness provided under any other group insurance or plan?	Name of Insuring Company
Yes <input type="checkbox"/> No <input type="checkbox"/>	

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 Insurance and Financial Service 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 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.

Dated this _____ of _____ Year _____	Claimant: _____
DAY MONTH YEAR (4 DIGITS)	Signature
Signed: _____	Date Signed (D D / M M / Y Y Y Y)
Camp Director	

