Post-Secondary Student Accident Claims Information Sheet

This document addresses frequently asked questions related to Post Secondary Student Accident Insurance claims

MEDICAL INJURY CLAIMS

- The Student Accident Insurance Post-Secondary 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 Student Accident Insurance Post-Secondary 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 STATEMENT OF SCHOOL AUTHORITY must be completed and signed by your **Authorized School Representative ONLY**. The claim cannot be processed in the absence of this authorization.
- The Student Accident Insurance Post-Secondary 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 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, benefits are coordinated. Please submit your medical 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.

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 INSURANCE AND FINANCIAL SERVICES INC.
Life and Health Claims Department, Special Markets Solutions
2165 Broadway W, PO Box 5900, Vancouver, BC V6B 5H6
Tel: 1-800-266-5667
www.solutionsinsurance.com

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.

iA Financial Group

Return to:
Life and Health Claims Dept.,
Special Markets Solutions
2165 Broadway W, PO Box 5900
Vancouver, BC V6B 5H6

Student Accident Insurance Post-Secondary Claim Form

Please print in ink

Claims Procedure

REVERSE SIDE MUST BE COMPLETED BY DOCTOR/DENTIST ON ALL INJURY CLAIMS.

IMPORTANT: Please attach **original receipts** for all eligible expenses. 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 no later than 1 year, regardless of whether expenses have been incurred. Return completed claim form to the above address.

Student Information

Full Name of Student

Surname | First Name | Initial | Sex M F | Date of Birth (D D / M M / Y Y Y Y)

Home Address

Street | City | Province | Postal Code

Current Mailing Address (If different from above)

Street | City | Province | Postal Code

Name of Parent or Guardian

Group Policy Number

Name of Post-Secondary Institute

Accident Information

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

Time of Accident A.M. ❑ P.M. ❑

Where did accident occur

Please explain, **in detail**, how accident happened *(If you require more space attach a seperate sheet of paper, signed and dated):*

What injuries were caused by accident?

Under whose immediate supervision was student at time of accident?

Treatment Received

On what date did you first consult Physician or Dentist? (D D / M M / Y Y Y Y)

Name and Address of Physician or Dentist

Are any benefits or services provided under any other group insurance or plan?

Yes ❑ No ❑

Name of Insuring Company

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 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 that the Company may need in their assessment of this claim.

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*

Statement of School Authority

Name of Student

Policy No. | Reg. No. | Name of Group

On the date of the accident, we certify that the above claimant was enrolled as a:

Full time student (3 or more courses) ❑ Part Time student ❑

Signed: _____ Date Signed (D D / M M / Y Y Y Y)

Signature of Person Authorized by Policyholder

The Claimant is responsible for securing this form and for charges incurred for its completion.

Section A - Attending Physician's Statement

Physician Information (Print)

Name

Address

City Province Postal Code

Telephone

Patient Information (Print)

Name

Address

City Province Postal Code

Telephone

1. Diagnosis including complications (If fracture, specify bones and type of fracture)

2. Did any disease or previous injury contribute to loss?

Yes ❑ No ❑ If Yes, describe

3. To the best of my knowledge

(a) Symptoms first appeared (D D/M M M/Y Y Y Y)

(b) Patient has had same or similar condition Yes ❑ No ❑

(c) If "Yes", state when and describe

4. Date of first visit for present disability (D D/M M M/Y Y Y Y)

Date of latest attendance (D D/M M M/Y Y Y Y)

Date of Surgery (D D/M M M/Y Y Y Y)

Treatment required

5. If referred to you give name of referring Physician

Physician's Signature

(D D/M M M/Y Y Y Y)

Section B – Attending Dentist's Statement

Dentist Information (Print)

Name

Address

City Province Postal Code

Telephone

Patient Information (Print)

Name

Address

City Province Postal Code

Telephone

Date of Service Day	Month	Year	Int. Tooth Code	Procedure Code	Tooth Surfaces	Laboratory Charge	Dentist's Fee	Total Charge

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

TOTAL SUBMITTED FEE ➔

Dentist's Signature Date DD MMM YYYY

For dentist's use only. For addtional information re: diagnosis, procedures, or complications, and special considerations.

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

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

Signature of patient (or parent/guardian)

Signature of subscriber

Dentist Supplementary Report (must be completed in full)

1. Description of damage

2. Teeth injured

3. Is further treatment indicated? No ☐ Yes ☐ If "Yes" please indicate:

Int.Tooth Code		Treatment indicated – Use procedure code if possible	Est. Date - Treatment DD	MMM	YYYY

Dentist's Signature

Date (DD/MMM/YYYY)