INDUSTRIAL ALLIANCE
INSURANCE AND FINANCIAL SERVICES INC.

www.inalco.com

GROUP INSURANCE

According to your plan, please submit the completed form to:

Quebec
Group Health and Dental Claims
PO Box 800, Station Maison de la Poste
Montreal, Quebec H3B 3K5

Ontario, Atlantic and Western Provinces
Group Health and Dental Claims
PO Box 4643, Station A
Toronto, Ontario M5W 5E3

CLAIM FORM
Dental Care – HSA

Please print in ink and sign.

PART 1: DENTIST'S STATEMENT

Patient (Last and first name)

For dentist's use only to provide additional information, diagnosis, procedures, or special considerations:

Duplicate ❑ Predetermination ❑

Dentist (Last and first name / Address / Phone no.)

I hereby assign my benefits payable from this claim to the named dentist and authorize payment directly to him/her.

Signature of subscriber

I understand that I am responsible for the fees incurred independent of the claim and the coverage I have. I acknowledge that the total fee of $_____ is accurate and has been charged to me for services rendered.

Member's signature _____

Verification (Dentist) _____

Treatment and services rendered to the patient

Date of service Y	M	D	Procedure code	Internal tooth code	Tooth surfaces	Dentist's fees	Laboratory charges	Total charges	HSA*
								$	☐
								$	☐
								$	☐
								$	☐
								$	☐
								$	☐
								$	☐

Excluding any possible errors or omissions, this is an accurate statement of services performed and the total fee due and payable.

Total $

PART 2: MEMBER'S STATEMENT

Policyholder's name _____ Policy no. _____

Member's last name _____ First name _____

Certificate no. _____ Date of birth Y M D _____ Sex: ❑ M ❑ F Language: ❑ E ❑ F

***Health Spending Account (HSA)**

Do you wish the unpaid portion of any expense provided for under the group policy to be paid under your HSA? ❑ Yes ❑ No

If yes, please indicate which expenses you wish to have the unpaid portion paid under your HSA. Please indicate the applicable expenses by checking off the box in the HSA column beside the "Treatment and services rendered to the patient" section above.

All dental care expenses which are not provided for under your group policy may be paid under your HSA.

Note: If the person for whom the claim is applicable has coverage elsewhere, you must first submit the expenses to the other carrier before requesting payment under your HSA.

COORDINATION OF BENEFITS

Under the coordination of benefits section of your plan, if one of your dependents is covered under a dental care benefit, the expenses incurred by your dependent must first be submitted to his/her insurer. You may subsequently submit a claim for the balance, if applicable, under your plan.

The expenses incurred by insured dependent children must be submitted to the plan of the parent whose birthday comes first during a calendar year.

Are you or your dependents, if applicable, covered by another group plan? ❑ No ❑ Yes If yes, specify:

Name of insurance company _____ Policy no. _____ Coverage: ❑ Individual ❑ Family

Name of spouse _____ Date of birth Y M D _____

CONTINUED ON THE NEXT PAGE

Member's last name _____ First name _____ Certificate no. _____

1. Patient's last name _____ Patient's first name _____

Relationship to member _____ Date of birth Y M D

Children 18 and over: ❑ Handicapped ❑ Full-time student If a full-time student, specify:

Name of school: _____

2. If the claim is the result of an accident, specify: ❑ Work ❑ Motor vehicle ❑ Other
and complete the "Dental Care in Case of an Accident" form (F54-267A)

3. Is any treatment planned for orthodontic purposes? ❑ Yes ❑ No

4. For a denture, crown or bridge, is this an initial placement? ❑ Yes ❑ No IF YES, please submit pre-treatment x-rays.

IF NO, specify date of prior placement Y M D and the necessity for replacement: _____

_____

_____

5. For a fixed bridge, have you or do you currently wear a partial denture? ❑ Yes ❑ No

IF YES, specify date of last placement Y M D and the necessity for replacement: _____

_____

MEMBER CONFIRMATION/AUTHORIZATION

I HEREBY CONFIRM:

1. that the information contained in this claim form is true and complete to the best of my knowledge;
2. that the persons for whom I am making a claim are eligible and that if the claim is being made on behalf of a dependent, I am AUTHORIZED to disclose information about him/her with respect to the claim; and
3. that if the claim is being made under my Health Spending Account
   (i) that the expenses are not eligible for reimbursement under the group policy with Industrial Alliance or any other plan;
   (ii) the expenses being claimed qualify for reimbursement under my Health Spending Account;
   (iii) that I understand that any expenses for which I am reimbursed under my Health Spending Account cannot be claimed for income tax purposes and should any tax consequences arise from the reimbursement of these expenses, I am responsible for payment of such taxes.

On behalf of myself and my dependents:

1. **I CONSENT TO THE RELEASE** of the information contained in this claim form to Industrial Alliance, its employees, agents, reinsurers and service providers for the purposes of underwriting, administration and processing of the claim; and
2. **I AUTHORIZE** any healthcare provider or professional, medical organization, insurance or reinsurance company, workers' compensation board, the policyholder, my employer, as well as any other person, private or public organization or institution to disclose to Industrial Alliance, its employees, agents and service providers any information regarding the treatment and expenses incurred which they may need in the assessment of the claim.

I AUTHORIZE Industrial Alliance to release to my employer/policyholder the amount of my account balance under the Health Spending Account when required for the provision/management of the Health Spending Account.

I AUTHORIZE the use of my Social Insurance Number as an identification number when it is required for the administration of the group policy.

I AGREE that a photocopy of this Confirmation/Authorization shall be as valid as the original.

Member's signature **X** _____ **Date** _____

Address _____ Postal code

Tel. home Tel. work Extension

YOUR HEALTH SPENDING ACCOUNT

ADDITIONAL INFORMATION

What expenses qualify for reimbursement

1. All expenses that qualify for the medical expense tax credit under the *Income Tax Act* are eligible. These may include expenses not covered by your heath or dental coverage (if any) under the group policy with Industrial Alliance.
2. Expenses which have been paid (or are eligible to be paid) by any other plan (including individual and government plans) do not qualify for reimbursement.

Filing a claim

1. The Health Spending Account is only to be used for expenses or a portion of the expenses which are not covered elsewhere. As a result when claiming:
   (a) for expenses of which a portion is payable under the group policy with Industrial Alliance, you must submit the claim under the policy at the same time you submit it under your Health Spending Account; or
   (b) any expenses of which a portion is payable under a plan other than the group policy with Industrial Alliance, you must first submit the claim under such plan. After a benefit has been paid under the plan, you should then submit the unpaid portion of the claim for payment under your Health Spending Account.
2. Any receipts (copies or originals) which you submit with a claim must include the following information:
   • Name of claimant
   • Nature of the treatment or type of dental treatment (eg. procedure code)
   • Name of the treating dentist
   • The date the claim was incurred
   • The amount charged

Before submitting a claim, make sure you have fully completed and signed all forms.
Incomplete forms will delay the processing of your claim.