iA Financial Group

CLAIM FORM

ACCIDENT / HEALTH INSURANCE BENEFIT

SECTION 1: INFORMATION CONCERNING PRIMARY INSURED

Name		Contract number	
Address		New address	☐ Yes ☐ No
		Email address	

SECTION 2: INFORMATION CONCERNING PATIENT

Name of patient	Date of birth			Relationship to participant	For children over age 21, indicate whether a full-time student (you must include a full-time study certificate).	Amount
	DD	MM	YY			
					☐ Yes ☐ No	$
					☐ Yes ☐ No	$
					☐ Yes ☐ No	$
					☐ Yes ☐ No	$

SECTION 3: FOR ACCIDENTS ONLY

1. Is any care being provided as the result of an accident ?	☐ Yes ☐ No
2. Give a brief description of the circumstances: where, when, how?	

SECTION 4: COORDINATION OF BENEFITS

If yes,	Are the following receipts covered by:	
☐ CSST		☐ SAAQ
Are the attached receipts covered by another group insurance or individual insurance plan?		
☐ yes	☐ no	
If yes,	Name of the insurance company:	

SECTION 5: TRANSPORTATION BY AMBULANCE

If your claim includes a receipt for ambulance services, please state the medical reason for the transportation:	

SECTION 6: DECLARATION

I declare that all the information provided is complete and true. I authorize any person concerned to disclose to my Insurer any information concerning this claim. The attached receipts (which the Insurer will neither return nor keep) support my claim with respect to services rendered to me or to eligible members of my family.

Date	Telephone no	Signature of the primary insured

SECTION 7: IMPORTANT NOTICE

To ensure prompt and efficient payment, please take note of the following:

- Submit your invoices on a regular basis or within 90 days of the date the services were rendered.
- Include only official, original receipts (these will not be returned). Duplicates and photocopies will not be accepted.
- The Primary Insured must indicate all the information requested and sign the form.

EXPENSES INCURRED DURING THE YEAR MUST BE SENT TO THE INSURER WITHIN 90 DAYS FOLLOWING THE END OF THE CALENDAR YEAR, BEFORE MARCH 31ST OF EACH YEAR.