



Student Accident Insurance Standard Claim Form

INDUSTRIAL ALLIANCE PACIFIC
INSURANCE AND FINANCIAL SERVICES™

Please Tell Us About Yourself

Name of Parent or Legal Guardian (please print) _____

Mailing Address
Street _____

City _____ Province _____ Postal Code _____

Telephone No: (home) _____ (business) _____

AREA CODE _____ AREA CODE _____

Student / Insured's Last Name _____ First Name _____ Initial _____

Date of Birth _____ Male Female

Name of School _____ Name of School Board _____

Grade/Year _____ Full-time Part-time Policy No: _____

Please Tell Us About the Accident

Date of Accident _____ Time of Accident _____ am pm

Where did the accident occur? _____

How did the accident happen? (Please provide a detailed explanation.)

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? No Yes

If Yes: Name of other insuring company _____

- 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 Life Insurance Company ("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.
- 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 _____ 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: _____

Accident Fracture Location & Type _____

Illness Other Injury Location & Type _____

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 _____ (DD/MMM/YYYY) Date of Surgery _____ (DD/MMM/YYYY) Was Claimant Hospitalized? No Yes

Name of Hospital _____ Date Admitted _____ (DD/MMM/YYYY)

Hospital Address _____ Date Discharged _____ (DD/MMM/YYYY)

Date: _____ DD / MMM / YYYY NAME OF PHYSICIAN (please print) _____ Signature of Attending Physician (M.D.) _____

Please Return To:

Industrial-Alliance Pacific Life Insurance Company, 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 Life Insurance Company ("IAP") 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.

