INDUSTRIAL ALLIANCE
INSURANCE AND FINANCIAL SERVICES INC.

Blanket Student Accident Claims Information Sheet

This document addresses frequently asked questions about Blanket Student Accident Insurance claims.

MEDICAL INJURY CLAIMS

- The Blanket Student Accident Insurance Standard Claim Form must be completed in full in order to process your claim. Please be sure to include the ***Attending Physician's Statement*** section 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 Admission or Emergency Room Report may be submitted instead of the Attending Physician's Statement. If you are claiming for the expense of an ambulance only, we **do not** require the attending Physician's Statement (nor the Hospital Admissions Report). Submit the original Ambulance invoice together with the top parts of the Student Accident claim form.
- If your policy provides **Physiotherapy coverage,** claims for these items must be accompanied by the original receipts and the written referral from the attending physician recommending physiotherapy treatment.
- If your policy provides coverage for **Brace expenses**, claims for these items must be accompanied by the original receipts and the written referral from the attending physician indicating that the brace is required for therapeutic or curative purposes only.

DENTAL INJURY CLAIMS

- The Blanket Student Accident Insurance Standard Claim Form must be completed in full in order to process your claim.
  If claiming for dental injury, please be sure that both the ***Part 1 & Part 2 Dentist*** sections on Page 2 of the claim form are completed by the attending dentist who saw the insured within 60 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 Blanket Student Accident Insurance Standard Claim Form must be filed with Industrial Alliance Insurance and Financial Services Inc., within 90 days of the date of the injury, regardless of whether expenses have been incurred. Attach only original receipts for all eligible expenses being claimed.
- Please note that it is the responsibility of the Parent/Legal Guardian to obtain and forward the completed claim form as indicated.
  Any charge incurred for its completion is also the responsibility of the Parent/Legal Guardian.
- If you have more than one insurance carrier, 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 Industrial Alliance with copies of expenses.
- Please note: In providing this claim form for the convenience of the claimant, Industrial Alliance 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.
- If you have any questions regarding coverage, your claim or require additional information, please contact our office at 1-800-266-5667 for instructions and information.

Return completed claim form to:
INDUSTRIAL ALLIANCE INSURANCE AND FINANCIAL SERVICES INC.
Claims Department, 2165 Broadway W, PO Box 5900, Vancouver, BC, V6B 5H6
Tel: 1-800-266-5667
www.inalco.com

Approved by CANADIAN DENTAL ASSOCIATION

Part 1 – Dentist

Dentist Information	Patient Information
Name	Name
Address	Address
City / Province / Postal Code	City / Province / Postal Code
Telephone	Telephone (home) / Telephone (work)

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

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

TOTAL SUBMITTED FEE ➔

Are any dental benefits provided under any other private or government plan or policy?

❑ No ❑ Yes

If yes, name of Plan/Company

____

Please do not forward x-rays, study models, or intra-oral photos unless requested by our office.

Dentist's Signature

Date | Day | Month | Year

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

Signature of the Patient (or Parent/Legal Guardian)

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

Signature of subscriber

Part 2 – Supplementary Dental Report (Must be Completed in Full)

1. Description of damage: ____

____

____

2. Teeth involved in the Accident: ____
3. Were these teeth whole or sound prior to the accident? No ❑ Yes ❑ If "No" Please indicate: ____________________

____

4. Is further treatment indicated? No ❑ Yes ❑ If "No" Please indicate:

Int. Tooth Code	Treatment indicated – Use procedure code if possible	Est. Date – Treatment		
		Day D D	Month M M M	Year Y Y Y Y

5. Describe further potential problems and indicate the time frame: ____

____

Dated this __________ of ____________________ Year __________
DAY MONTH YEAR (4 DIGITS)

____
Dentist's Signature