Blanket Student Accident Insurance
Standard Claim Form

Please print in ink

Please Tell Us About Yourself

Name of Parent or Legal Guardian (please print)

Name

Address

City | Province | Postal Code

Telephone (home) | Telephone (work)

Insured's Information (Print)

Last Name | First Name | Initials

Date Of Birth (D D M M M Y Y Y Y)

Sex ❑ Male ❑ Female

Name Of School | Grade/Year

Name Of School Board: Palliser Regional Schools | Policy #: 100007783

Please Tell Us About the Accident

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

Time Of Accident (H H M M) ❑ am ❑ pm

Where did the accident occur?

How did the accident happen? (Please priovide a detailed explaination)

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?

❑ Yes ❑ No

If Yes: Name of other insuring company

1. I hereby CERTIFY that the information contained in this Claim Form is true and complete to the best of my knowledge.
2. On behalf of myself and/or any minor insured, I RELEASE the information contained in this Claim Form to Industrial Alliance Pacific Insurance and Finacial Services Inc. ("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.
3. 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 _____ Claimant: _____
DAY | MONTH | YEAR (4 DIGITS) | *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: _____ due to: Accident ❑ or Illness ❑

Fracture and/or Other Injury ❑ Location & Type _____

Referred for: Physiotherapy ❑ Massage Therapy ❑ ?

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

Date of surgery _____ (D D / M M M / Y Y Y Y) Under general anaesthetic ❑ or under local anaesthetic ❑ ? Was Claimant hospitalized? ❑ No ❑ Yes

Name of Hospital _____ Date Admitted _____ (D D / M M M / Y Y Y Y)

Hospital Address _____ Date Discharged _____ (D D / M M M / Y Y Y Y)

Date: _____ _____ _____
D D / M M M / Y Y Y Y | *NAME OF PHYSICIAN (please print)* | *Signature of Attending Physician (M.D.)*

Please Return To: Industrial Alliance Pacific Insurance and Financial Services Inc., 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 Insurance and Financial Services Inc.,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.

Approved by CANADIAN DENTAL ASSOCIATION

Part 1 – Dentist

Dentist Information

Name

Address

City Province Postal Code

TelephonePatient

Patient Information

Name

Address

City Province Postal Code

Telephone (home) Telephone (work)

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

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*