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To submit your claim directly to the Insurer, please send this form to:

**Industrial Alliance**  
PO Box 4643, Station A  
Toronto, Ontario M5W 5E3

To submit your claim through your Employer's Plan Administrator, please send this form to:

**J & D Benefits Administration Ltd**  
8901 Woodbine Avenue, Suite 228  
Markham, Ontario L3R 9Y4

**CLAIM FORM**  
**MEDICAL EXPENSES**

Policyholder's name \_\_\_\_\_

Policy no. \_\_\_\_\_ Division no. \_\_\_\_\_ Class no. \_\_\_\_\_

Member's last name \_\_\_\_\_ First name \_\_\_\_\_

Certificate no. \_\_\_\_\_ Date of birth \_\_\_\_\_ Sex:  M  F Language:  E  F

**POLICYHOLDER'S STATEMENT** (To be completed by the plan administrator, only if your group is self-administered)

	Member	Spouse	Child
Effective date	_____	_____	_____
Termination date	_____	_____	_____
Authorized representative	_____ Date _____		

**COORDINATION OF BENEFITS**

Are you or your dependent covered by another group plan?  No  Yes Specify: \_\_\_\_\_

Name of insurance company \_\_\_\_\_ Policy no. \_\_\_\_\_ Coverage:  Individual  Family  
Name of spouse \_\_\_\_\_ Date of birth \_\_\_\_\_

**MEDICAL EXPENSES**

(Attach the original receipts and keep a copy for income tax purposes and the coordination of benefits. If there are three originals, please enclose Original 1.) The receipts will not be returned and they will be destroyed 60 days after receipt.

NAME (member or insured dependent)	RELATIONSHIP TO THE MEMBER	DATE OF BIRTH Y M D	18 and over Full-time student		Handicapped child		CHILDREN 18 AND OVER Name of school	TOTAL
			No	Yes	No	Yes		
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	\$ _____
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	\$ _____
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	\$ _____
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	\$ _____

If there are expenses for the rental or purchase of an appliance, please attach a letter from your physician describing the diagnosis.

Expenses following an accident?  No  Yes Nature of accident:  Work  Motor vehicle  Crime victim  Other \_\_\_\_\_  
Date of accident \_\_\_\_\_ Place of accident \_\_\_\_\_

**AMBULANCE TRANSPORTATION FEES** (Enclose the receipt from the ambulance service)

Reason for ambulance service \_\_\_\_\_  
Place of pick-up:  Home  Work  Other Specify \_\_\_\_\_

**EXPENSES INCURRED OUTSIDE THE PROVINCE OF RESIDENCE**

If the medical expenses were incurred outside the province of residence, please complete "MEDICAL EXPENSES INCURRED OUTSIDE THE PROVINCE OF RESIDENCE" (F54-371A). To obtain a copy of this form, please call (514) 499-3747 or 1-800-203-9024 if you are calling from outside the Montreal area.

**MEMBER CONFIRMATION/AUTHORIZATION**

I HEREBY CONFIRM that the information contained in this Claim Form is true and complete to the best of my knowledge.  
I HEREBY CONFIRM that the expenses were incurred by myself or by one of my insured dependents and are required in connection with the treatment of a medical condition.  
If this claim is being made on behalf of my spouse and/or dependent children, I CONFIRM that I am AUTHORIZED to disclose information about them with respect to this claim.  
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, public or private organization or institution to disclose to Industrial Alliance, its employees, agents and service providers any information regarding the treatment and charges incurred which they may need in the assessment of the claim.  
I AUTHORIZE the use of my Social Insurance Number as an identification number where 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 ( ) \_\_\_\_\_