If you have any questions or require any assistance with the completion of Claim Forms, please contact our office at: 1 800-266-5667 or email: specialmarkets-claims@ia.ca

Specific Loss – Loss of Use Claim Form

Claim Information and Documents Required

- Complete all sections of the Claim Form that apply based on the Supporting Documents listed below.
- The Physician Statement must be completed by an Attending Physician (M.D).
- The claimant is responsible for having the required forms completed at their own expense.
- To ensure prompt handling of your claim, please ensure that all claims documents are fully completed, and the required supporting documentation is provided at the time of claim.
- Please note that this list is not exhaustive and other documents may be required to complete the assessment of your claim.

*** The document which describes your coverage may be called an Insurance Certificate or a Summary of Insurance.**

!	**Claim Form must be completed with all the Supporting Documents Required**

SUPPORTING DOCUMENTS REQUIRED

- ❑ Completed Specific Loss – Loss of Use Claim Form
- ❑ Completed Physician Statement (M.D)
  Provide copies of any medical information from your physician
- ❑ Completed Employer Statement
- ❑ Signed Authorization Form

In providing claim forms for the convenience of the claimant, the Company 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.

PLEASE RETURN ALL CLAIM FORMS AND SUPPORTING DOCUMENTATION TO OUR OFFICE BY MAIL OR FAX

Industrial Alliance Insurance and Financial Services Inc.
iA Special Markets (Claims Department)
400–988 Broadway West,
PO Box 5900, Vancouver, BC V6B 5H6

Tel 1 800-266-5667
Fax 1 866-913-3620

Industrial Alliance Insurance and Financial Services Inc.
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PO Box 5900, Vancouver, BC V6B 5H6

Telephone 1 800-266-5667
Fax 1 866-913-3620
Email specialmarkets-claims@ia.ca
Website ia.ca

Specific Loss – Loss of Use Claim Form

Claimant Statement

Last Name | First Name | Sex ☐ M ☐ F | Date of Birth (yyyy-mm-dd) | Provincial Health Card #

Unit Number | Street Address | City | Province | Postal Code

Home Phone | Cell Phone | Email

Claim is for: ☐ myself ☐ my spouse ☐ my dependent – please specify name

Relationship to Insured | Date of Birth of Spouse/Dependent (yyyy-mm-dd)

Date of Accident (yyyy-mm-dd) | Location of Accident | Time ☐ A.M. ☐ P.M.

How did the accident occur? Please provide details of accident (i.e. place, injury sustained).

Date of first medical visit following injury (yyyy-mm-dd) | Name and Address of Dentist or Physician first attended

Name and Address of Hospital where you or your dependent stayed | Hospitalization period

Names and addresses of physicians who have treated you or your dependent since the accident occurred	Addresses	Phone Numbers

Have you or your dependent applied for benefits under:

☐ Workers' Compensation Legislation ☐ Provincial Automobile Insurance Legislation ☐ Other – please specify

Please provide any information which might assist Industrial Alliance Insurance and Financial Services Inc. in processing this claim:

I declare that the information provided in the Claim Form is accurate and any statements provided in any personal or telephone interview concerning this claim will be true and complete. I agree that all such statements form the basis for any benefit approved as the result of this claim.

Claimant's Name (Please Print)

Signature of Claimant or Parent or Legal Guardian (if minor) | Date Signed (yyyy-mm-dd)

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Specific Loss – Loss of Use Claim Form

Employer Statement

Policy Number

Certificate No.

Effective Date of Coverage (yyyy-mm-dd)

Last Name of insured

First Name of insured

Date of Birth (yyyy-mm-dd)

Occupation

Plan of Insurance — CLASS

Annual Salary

Amount of the Accidental Dismemberment Benefit

Amount of Group Life Insurance

Amount of claim

Date of Hire

Date of Last Premiums Paid

Date Last Reported to Work

Was Insured covered under WSIB? ☐ Yes ☐ No If Yes, Claim#

Was the Insured travelling on Company business at the time of accident? ☐ Yes ☐ No

Is this a workplace injury? ☐ Yes ☐ No

Name of Authorized Person

Title

Telephone

Email

Signature

Date Signed (yyyy-mm-dd)

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Specific Loss – Loss of Use Claim Form

Authorization Form

PRIVACY STATEMENT

At Industrial Alliance Insurance and Financial Services Inc., ("the Company") we recognize and respect every individual's right to privacy. Personal information about you is kept in a confidential claim file at the offices of the Company or of an organization authorized by the Company in a secure area. We limit access to information in your files to The Company staff or persons authorized by the Company who require this access to perform their duties, to persons to whom you have granted access, and to persons authorized by law. We use this information to investigate, assess and administer your claim and the terms of the Insurance contract provisions. You may access the personal information contained in your file and correct any inaccurate information. Any personal health information will be provided to you through a medical practitioner of your choice. To view your personal information please send a request in writing to the attention of the Claims Department at the above address, together with the name of the Medical practitioner.

AUTHORIZATION AND DECLARATION

I hereby authorize Industrial Alliance Insurance and Financial Services Inc., ("the Company") for the purposes of investigation, evaluation and administration of my claim:

a) to gather only the information necessary for the above specified purposes from any person or organization that has personal information relating to me, including other insurers, reinsurers, and financial institutions; physicians, medical institutions and healthcare providers; employers or administrators of group benefits; agents or brokers; investigating and credit reporting agencies, and all persons or organizations likely to have personal information relevant to my claim.

b) to disclose and exchange only the necessary personal information the Company has relating to me to the above persons and organizations.

I understand that the personal information obtained using this authorization will be used by the Company in the investigation, administration and evaluation of a claim for benefits. Any information obtained will not be released by the Company, except to persons or organizations performing business or legal services in connection with my claim, or as may be otherwise lawfully required or as I may further authorize.

I confirm that a photocopy or electronic copy of this authorization shall be valid as the original.

I declare that the information provided in the Claim Form is accurate and any statements provided in any personal or telephone interview concerning this claim will be true and complete. I agree that all such statements form the basis for any benefit approved as the result of this claim.

Claimant's Name (Please Print) _____

Signature of Claimant or Parent or Legal Guardian (if minor) _____ Date Signed (yyyy-mm-dd) _____

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Specific Loss – Loss of Use

Physician Statement

! TO BE COMPLETED BY A MEDICAL DOCTOR (M.D.)
FOR MEDICAL EXPENSES, DISMEMBERMENT OR TOTAL AND PERMANENT LOSS OF USE
THE CLAIMANT IS RESPONSIBLE FOR ANY FEE FOR THIS INFORMATION.

Date of Accident (yyyy-mm-dd) | Date of first attendance for this injury (yyyy-mm-dd) | Nature of Injury

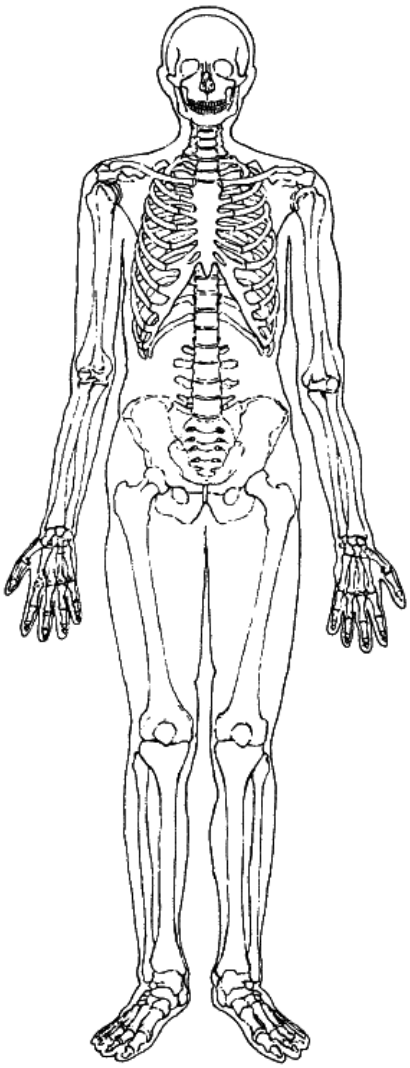
☐ **Fracture:** Location and Type ☐ **Other Injury:** Location and Type

Visual Injury ☐ Yes ☐ No If "Yes", please provide details:

Was surgery required? ☐ Yes ☐ No Surgery Date (yyyy-mm-dd) General Anesthetic ☐ Yes ☐ No

! Please complete the following section if patient's claim is for Dismemberment and Total and Permanent Loss of Use.

Nature of Loss? State right or left on chart, please mark point of any amputation. ➔➔➔



Did any Sickness, Disease or previous Injury contribute to the loss? ☐ Yes ☐ No

If "Yes", describe

What evidence of trauma did you find?

Degree of loss

Is loss permanent and irrecoverable? ☐ Yes ☐ No

Was injury sufficient to produce total and permanent loss? ☐ Yes ☐ No

If "Yes", please provide supporting medical documents (i.e. specialist, consultation, operative & rehabilitation reports).

Was claimant hospitalized? ☐ Yes ☐ No Hospital Name Date admitted (yyyy-mm-dd)

! Names and addresses of other physicians or surgeons, if any, who attended claimant

Names of other physicians or surgeons	Addresses	Phone Numbers

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE.

Physician Name (Please print) | Address | Telephone

Signature | Date Signed (yyyy-mm-dd)