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

Emergency Out of Province/Country

Claims Information and Documents Required

- The Out-of-Province/Country Insurance Claim Form must be submitted within 90 days of the expenses incurred and no later than one year (12 months).
- A separate claim form must be completed for each illness/injury.
- To ensure prompt handling of your claim, please ensure that all claims documents are fully completed and the supporting documentation provided at the time of claim.
- If you have submitted these expenses to any other insurance you may have, please provide explanation of benefits showing the amounts covered and paid by them. (i.e.: credit card insurance, coverage through spouse policy)
- Please note that this list is not exhaustive and other documents may be required to complete your claim.
- Original receipts are not required, however, please retain originals for 12 months following the date you submitted the claim.
- Please provide the following supporting documentation with your duly completed form. Be sure to keep a copy of these documents for your records.
- Submit all forms together to the Company at the address below. You may also send your claim forms by fax. We wish to remind you that email is not a secure method of communication and should only be used to transmit non-confidential information.

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

SUPPORTING DOCUMENTS REQUIRED

- ❑ Completed Out of Province/Country Claim Form
- ❑ Copies of any medical information you may have been provided with in relation to your diagnosis/treatment
- ❑ Any other document containing relevant information pertaining to the medical consultation or treatment
- ❑ Copy of your Provincial Health Insurance Card. If claim is for dependent/spouse, copy of their Provincial Health Insurance Card
- ❑ Provide Proof of Travel dates from/to Canada that applies from the list below:
  - Copies of airline tickets showing your departure and return dates from/to your province of residence
  - Copies of Trip Log (commercial truck drivers) showing your departure and return dates from/to your province of residence
  - Copies of accommodation receipts
- ❑ Copies of any invoices you may have been billed or paid out of your pocket. Please keep the original receipts for 12 months
- ❑ Copy of Credit Card Statement outlining the exchange rate, if expenses were paid for on your Credit Card

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

iA Financial Group is a business name and trademark of Industrial Alliance Insurance and Financial Services Inc.

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Fax 1 866-913-3620
Email specialmarkets-claims@ia.ca
Website ia.ca

Emergency Out of Province/Country

Claim Form

! To avoid any delays in processing of your claim, please send the duly completed claim form with all the supporting documents required.

CONTRACT HOLDER INFORMATION

Policy Number | Member ID | Contract Holder's Provincial Health Card Number

Contract Holder's Last Name | Contract Holder's First Name | Date of Birth D D - M M M - Y Y Y Y | Sex ❑ M ❑ F

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

Home Phone | Cell Phone | Email

Did you call our assistance line within 24 hours? ❑ Yes ❑ No If Yes, please provide your Case Number:

Name of Claimant (if different from Contract Holder) | Date of Birth D D - M M M - Y Y Y Y | Relation to Contract Holder | Claimant's Provincial Health Card Number

TRAVEL/TRIP DETAILS

Departure Date D D - M M M - Y Y Y Y | Scheduled Date of Return (if different from Actual Return Date) D D - M M M - Y Y Y Y | Actual Return Date D D - M M M - Y Y Y Y | Destination

Reason for Travel

❑ Business ❑ Vacation ❑ Study ❑ Medical Care ❑ Other:

Mode of Travel

❑ Car ❑ Airplane ❑ Other:

MEDICAL/DENTAL SERVICES OUTSIDE OF YOUR PROVINCE

Indicate the reason why you received medical/dental or hospital services, please provide details:

Were these services required as the result of an accident? ❑ Yes ❑ No If Yes, please provide details:

Date of Accident D D - M M M - Y Y Y Y | Place of Accident

Date of Hospital/Clinic/Dental Visit D D - M M M - Y Y Y Y | Name of Physician or Dentist Consulted

Street Address of Hospital/Clinic/Dental Clinic | City | Province | Postal Code

MEDICAL/DENTAL SERVICES IN YOUR PROVINCE OF RESIDENCE

Have you consulted a doctor/dentist or specialist prior to your trip? ❑ Yes ❑ No

If Yes, please indicate the date of **last** visit: D D - M M M - Y Y Y Y Reason of visit:

Please list all medication in use **before** your departure date

Any medication change before your departure date?
❑ Yes ❑ No If Yes, provide details on an additional page.

Name of Family Physician in Canada | Phone Number

Street Address Family Physician in Canada | City | Province | Postal Code

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REIMBURSEMENT

Amount Claimed

Currency
❑ Canadian Dollar ❑ Other:

Were bills paid? If Yes, please submit proof of payment.
❑ No ❑ Yes (❑ Full ❑ Partial)

OTHER TRAVEL INSURANCE INFORMATION

Do you carry other travel medical insurance or Group Insurance through Employer?
(This includes coverage offered through premium credit cards) ❑ Yes ❑ No

Have you submitted this claim to the Other insurance company? ❑ Yes ❑ No

If Yes to questions above, please provide:

Name of the Other Travel or Group Insurer	Policy Number	Claim Number	Date submitted claim to the Other Insurer
			DD-MMM-YYYY

Street Address of Employer	City	Province	Postal Code

Automobile Accident

If injuries are the result of an automobile accident, please provide:

Name of the Automobile Insurer	Policy Number	Claim Number	Name of Insured, if other than yourself

Street Address of Insured, if other than yourself	City	Province	Postal Code	Phone Number

AUTHORIZATION AND DECLARATION

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 Insurance and Financial Services Inc. (the "Company") 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 the Company any medical information, information regarding charges, or other information that the Company may need in their assessment of this claim.
I AUTHORIZE the Company 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.

Claimant's Name (Please Print)

Signature of Claimant
or Parent or Legal Guardian (if minor)

Date Signed DD-MMM-YYYY

PRIOR TO SUBMITTING YOUR CLAIM

Please refer to the Claims Information and Documentation Required page to ensure that you provide all the necessary documents applicable to your claim. A photocopy or a fax of this authorization shall be considered as valid as the original. *** Ensure that the original receipts are kept for 12 months following the date claim is submitted.**

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