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

Preliminary Proof of Loss (Disability, Waiver of Premiums & Weekly Accident Indemnity)

Claims Information and Documents Required

- Complete all sections of the Claimant's Statement Form and submit your claim with an Attending Physician's Statement, Employer's Statement and other Supporting documents listed below.
- The claimant is responsible for having the required forms completed at their own expense.
- The Physician's Statement must be completed by a Licensed Medical Doctor (MD). Physician's Statement completed by a Physiotherapist or Chiropractor will not be accepted.
- In the event that the insured was initially seen in a hospital, a copy of the Hospital Discharge summary may be submitted instead of the Attending Physician's Statement.
- To ensure prompt handling of your claim, please ensure that all claims documents are fully completed, and the required supporting documentation provided at the time of claim.
- **Coordination of benefits** for dental, hospital, paramedical, eyewear and emergency care expenses:
  You must always submit claims for reimbursement to your other plans first (public, private or group insurance plans). Once you receive a copy of the other insurance company's Explanation of Benefits, please send them to us to complete your claim.
- 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 original for 12 months following the date you submitted the claim.
- The claimant is responsible for any fees needed to complete the forms.
- Submit all forms together to the Company at the address below. You may also send your claim forms by fax or email. However, 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**

BENEFIT CLAIMING FOR	**SUPPORTING DOCUMENTS REQUIRED**
Disability/Weekly Accident Indemnity	❑ Completed Claimant's Statement Form ❑ Completed Physician's Statement (MD) ❑ Completed Employer's Statement • For employees: Tax slips for the past two years • For self-employed: Federal and Provincial tax returns for the past two years ❑ Signed Authorization Form ❑ Copies of Two (2) recent Pay Stubs ❑ Copy of Accident Report (if applicable)
Hospital, Paramedical, Counselling and Prosthetics	❑ Completed Physician's Statement (MD) ❑ Physician's Referral required for Paramedical and Counselling benefits.
Waiver of Premiums	❑ Completed Claimant's Statement Form ❑ Completed Physician's Statement (MD) ❑ Completed Employer's 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.
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400–988 Broadway West,
PO Box 5900, Vancouver, BC V6B 5H6

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Preliminary Proof of Loss Claim Form - Claimant's Statement

SECTION A

Benefit Applying For: ☐ Waiver of Premiums ☐ Disability ☐ Weekly Accident Indemnity

Policyholder's Name | Policy No.: | Claim No.:

Claimant's Name | Age | Date of Birth (D D / M M M / Y Y Y Y) | Sex ☐M ☐F | S.I.N.

Mailing Address/Street:

City | Province | Postal Code | Home Phone Number

Email Address | Cell Phone Number

SECTION B

1. **a.** Occupation at time of disability _____ **b.** Gross annual income: _____ **c.** ☐ Employee ☐ Self-employed ☐ Unemployed
2. Brief description of employment (% of tasks that are physical, administrative, etc.)

   _____
3. Name of Employer: _____ Address: _____
4. Are you still employed there? ☐ Yes ☐ No If not, since when? _____ (dd/mmm/yyyy)
5. Is this seasonal work? ☐ Yes ☐ No If so, usual work period: _____
6. **a.** If employee, date you stopped working for medical reasons: _____ (dd/mmm/yyyy) **b.** If unemployed, date total disability began: _____ (dd/mmm/yyyy)
7. **a.** Other sources of Income? ☐ Yes ☐ No If yes, which one? ☐ WCB/CSST ☐ EI Sickness ☐ EI ☐ CPP/QPP Disability ☐ CPP/QPP Retirement

   All other sources such as insurance companies, etc.: (Specify) _____ ☐ Group Insurance ☐ Individual Disability ☐ Mortgage disability

   b. Decision: ☐ Pending ☐ Accepted ☐ Denied ☐ Under Appeal **c**. If accepted, amount of claim: $ _____ ☐ Bi-weekly ☐ Monthly

   d. Are you still receiving these benefits? ☐ Yes ☐ No since _____ (dd/mmm/yyyy) **(Note: Enclose copy of all documentation received from the organization)**
8. **a.** Are you still completely disabled? ☐ Yes ☐ No since _____ (dd/mmm/yyyy)

   b. When did you or will you resume part-time work? from: _____ (dd/mmm/yyyy) to _____ (dd/mmm/yyyy)

   c. When did you or will you resume full-time work? _____ (dd/mmm/yyyy)

SECTION C

1. Describe the nature of your disability: _____
2. **a.** If illness, symptoms first appeared on: _____ (dd/mmm/yyyy) Diagnosis: _____

   b. If accident, Date of accident: _____ (dd/mmm/yyyy) Time: _____ ☐ AM ☐ PM Location _____

   How did this accident occur? Describe: _____

   c. If motor vehicle accident, you were the: ☐ Driver ☐ Passenger

   Witnesses Names: _____ Address: _____
3. Date you first consulted a Physician for this condition: _____ (dd/mmm/yyyy)

   Name of Physician _____ Address _____ Phone number _____
4. Where and when did your Physician attend you? ☐ Clinic ☐ Hospital ☐ Home Date: _____ (dd/mmm/yyyy) Time: _____ ☐ AM ☐ PM
5. **a.** Have you ever had the same or a similar illness before? ☐ Yes ☐ No If Yes state when: _____ (dd/mmm/yyyy)

   b. Provide details: _____ **c.** Name of Physician: _____
6. **a.** Has any other Physician treated you for this accident or sickness? ☐ Yes ☐ No If Yes state when: _____ (dd/mmm/yyyy)

   b. Physician's Name _____ Address: _____
7. What medical attendance have you had during the past five years? _____
8. **a.** When did you or will you resume part-time work? _____ (dd/mmm/yyyy) Time _____ AM/PM

   b. When did you or will you resume full-time work? _____ (dd/mmm/yyyy) Time _____ AM/PM

I declare that the information provided in this claim is accurate and any statements provided in any personal or telephone concerning this claim will be true and complete. I acknowledge receipt of the attached Authorization and Declaration.

Dated _____ (dd/mmm/yyyy) Signature of Claimant _____

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Attending Physician Statement

PATIENT IDENTIFICATION

Patient Name

Date of Birth (dd-mmm-yyyy)

PATIENT HISTORY

Did your patient attend the Hospital Emergency? ☐ Yes ☐ No

If yes, since (dd-mmm-yyyy)

If no, name of the family physician

Was this patient referred to you by another physician? ☐ Yes ☐ No

If yes, please identify

Other physicians consulted or referred to regarding the current disability:

Name of physicians

Specialty

DISABILITY HISTORY

Date total disability began (dd-mmm-yyyy)

Date of accident or occurrence of first symptoms (dd-mmm-yyyy)

Date of first visit for present period of disability (dd-mmm-yyyy)

Date of last visit (dd-mmm-yyyy)

Frequency of visits: ☐ Weekly ☐ Monthly ☐ Other:

Disability related to: ☐ Illness ☐ Work accident ☐ Motor vehicle accident ☐ Other:

If relapse, date on which total disability reoccurred (dd-mmm-yyyy)

DIAGNOSIS

Primary:

Secondary – related condition(s) and medical complication(s):

Investigations results (X-rays, lab tests, etc.):

Has patient already had same or similar condition? ☐ Yes ☐ No ☐ Unknown

If yes, please provide date (dd-mmm-yyyy) and describe

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Attending Physician Statement (con't)

SYMPTOMS / LIMITATIONS

What symptoms and limitations were found following your assessment? Indicate degree of severity (M = Mild, Md = Moderate, S = Severe)

Symptoms:		Functional limitations:	
	☐ M ☐ Md ☐ S		☐ M ☐ Md ☐ S
	☐ M ☐ Md ☐ S		☐ M ☐ Md ☐ S
	☐ M ☐ Md ☐ S		☐ M ☐ Md ☐ S

Functional limitations are ☐ Temporary ☐ Permanent

TREATMENT

Medications (name and dosage):

☐ Physiotherapy ☐ Occupational therapy ☐ Psychotherapy ☐ Other:

Therapy frequency: ☐ Ongoing ☐ Completed

Response to treatment: ☐ Good ☐ Partial ☐ None ☐ Too soon to determine

If hospitalization, from (dd-mmm-yyyy) to (dd-mmm-yyyy) ☐ Currently hospitalized

Name of hospital:

Reason for hospitalization:

If applicable, planned surgical procedure (description):

Date (dd-mmm-yyyy)

PROGNOSIS

Does the patient's medical condition make him/her unable to perform his/her own occupation? ☐ Yes ☐ No

If no, since (dd-mmm-yyyy)

If yes, how long before the patient will be able to return to work?

Weeks Months ☐ Undetermined or Date of return to work (dd-mmm-yyyy)

☐ *Return to pre-injury occupation not possible*

If applicable, if the patient is not in the labour market, approximate duration of disability:

Weeks Months ☐ Undetermined or End of disability on (dd-mmm-yyyy)

Can the patient perform another occupation? ☐ Yes ☐ No

If yes, beginning (dd-mmm-yyyy)

Do you consider the patient to be fully and permanently disabled? ☐ Yes ☐ No ☐ Too soon to determine

The patient's condition: ☐ is stable ☐ has improved ☐ has deteriorated

The prognosis is: ☐ Favourable ☐ Reserved ☐ Reduced life expectancy

Is there other information you would like to add regarding the patient's health (including non-medical factors)?

PHYSICIAN IDENTIFICATION

Physician Name (Please print)

Licence no.

☐ General practitioner ☐ Specialist, specify:

Address

Telephone

Fax

Signature of Physician

M.D.

Date Signed (dd-mmm-yyyy)

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Employer's Confirmation of Income & Benefits

! Employer's Statement must be fully completed and signed by an authorized representative of the company.

EMPLOYER'S STATEMENT

Employer's Name

Employer's Address

Employer's Phone No.

Employer's Fax No.

Employer's Email Address

Employee's Name

Policy Number

Occupation

Please check the applicable box below

☐ Full Time ☐ Part Time ☐ Casual

1. (a) What are the physical requirements of the job? ☐ Heavy manual labour ☐ Light manual labour ☐ Sedentary

   (b) Please give a brief job description including Physical and Administrative duties: (Please attach job description if available)

2. What is the rate of pay (excluding bonus, commissions and over-time pay)? Per Hour: $ _____ & Per Week: $ _____

3. What are the average hours worked, excluding over-time hours? Per Day: _____ hrs & Per Week: _____ hrs

4. (a) What was the last day worked? _____

   (b) What was the reason for stopping work? _____

5. Length of time employed:

   From: Day _____ Month _____ Year _____ **To:** Day _____ Month _____ Year _____

6. Does this employee pay 100% of the premium for the Disability Benefit claimed for? ☐ Yes ☐ No

7. Is this employee eligible for Income Replacement and/or Group Disability Benefits? ☐ Yes ☐ No If Yes, please advise below:

   (a) Paid or will be paid while off work: _____

   (b) Paid by whom? _____

   (c) Length of time payable? _____

8. Is this employee eligible for Workers' Compensation or Equivalent Plan? ☐ Yes ☐ No If Yes, please advise below:

   Is this employee eligible for Workers' Compensation or Equivalent Compensation as a result of the accident? ☐ Yes ☐ No

   (a) When did / will employee resume Part Time work? Date: _____ Time: _____ AM / PM

   (b) When did / will employee resume Full Time work? Date: _____ Time: _____ AM / PM

EMPLOYER'S SIGNATURE

Authorized Signature

X

Title

Name (please print)

Date Signed

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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) _____