



Please print in ink

IMPORTANT: Please attach **original receipts** for all eligible expenses. Completed claim form must be filed with Industrial Alliance Insurance and Financial Services Inc. (the "Company") within 90 days after the date of the injury, and no later than 1 year, regardless of whether expenses have been incurred.

Return completed claim form to the above address.

Surname _____ First Name _____ Initial _____ Sex ☐ M ☐ F

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

Street _____ City _____ Province _____ Postal Code _____

Street _____ City _____ Province _____ Postal Code _____

[illegible]

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

Please explain, **in detail**, how accident happened (If you require more space attach a seperate sheet of paper, signed and dated):

Under whose immediate supervision was student at time of accident?

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

Yes ☐ No ☐

Are any expenses submitted to ClaimSecure? Yes ☐ No ☐ If Yes, provide EOB from ClaimSecure:

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.

Dated this _____ of _____ Year _____ Claimant: _____
DAY MONTH YEAR (4 DIGITS) Signature

Name of Group

100011699	Niagara College Student Administrative Council
-----------	--

Full time student (3 or more courses) ☐ Part Time student ☐ International Student ☐

Signed: _____ Date: _____
 _____ Signed: _____
 Signature of Person Authorized by Policyholder (D D / M M / Y Y Y Y)

Signature of Person Authorized by Policyholder

The Claimant is responsible for securing this form and for charges incurred for its completion.

Section A - Attending Physician's StatementPhysician Information (Print)
Name

Address

City Province Postal Code

Telephone

Patient Information (Print)
Name

Address

City Province Postal Code

Telephone

1. Diagnosis including complications (If fracture, specify bones and type of fracture)

2. To the best of my knowledge

(a) Symptoms
first appeared

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

(b) Patient has had same or similar condition
Yes ☐ No ☐

(c) If "Yes", state when and describe

3. Date of first visit for present condition

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

Date of latest attendance

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

Date of Surgery

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

Treatment required

4. Does your patient require any referral (i.e. Physio, chiro, etc.)? Yes ☐ No ☐ If "Yes", please describe:

Physician's Signature

Date (DD/MMM/YYYY)

Section B - Attending Dentist's StatementDentist Information (Print)
Name

Address

City Province Postal Code

Telephone

Patient Information (Print)
Name

Address

City Province Postal Code

Telephone

Date of Dental Visit

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

Date of Initial Dental Attention

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

Teeth involved in the Accident:

Reason of Dental Visit

Accident: Yes ☐ No ☐ Emergency Dental Visit: Yes ☐ No ☐ Other, please describe:

If "Yes", provide details:

Description of damage:

Were these teeth whole or sound prior to the accident? No ☐ Yes ☐ If "No", please describe:Is further treatment indicated? No ☐ Yes ☐ If "Yes", please describe:

Dentist's Signature

Date (DD/MMM/YYYY)

**Please attach a Standard Dental Claim Form, available at your Dentist's office,
fully completed and signed by your dentist for the dental treatment received.**

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 release of the information contained in this claim form to my insuring company or its agents. I also authorize the communication of information related to the coverage of services described in this form to the named dentist.

I hereby assign benefits payable from this claim to the above named dentist and authorize payment directly to the dentist.

Signature of patient (or parent/guardian)

Signature of subscriber

Date (DD/MMM/YYYY)