



Please Tell Us About Yourself

Name of Parent or Legal Guardian (please print)

Mailing Address
Street
City Province Postal Code
Telephone No: (home) (business)
AREA CODE AREA CODE

Insured's Last Name First Name Initial
Date of Birth Male Female
Name of School Name of School Board
Grade/Year Policy No:
or
School Board No.: 0 1 2 0

Please Tell Us About the Accident

Date of Accident Time of Accident am pm
Where did the accident occur?
How did the accident happen? (Please provide a detailed explanation.)
What injuries were caused by the accident?

On what date was the Physician or Dentist first consulted for this injury?
Name & Address of Dentist or Physician:
Are any other hospital and medical or dental insurance benefits available? No Yes
If Yes: Name of other insuring company

- 1. I hereby CERTIFY that the information contained in this Claim Form is true and complete to the best of my knowledge.
- 2. On behalf of myself and/or any minor insured, I RELEASE the information contained in this Claim Form to Industrial Alliance Pacific Life Insurance Company ("IAP") 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 IAP any medical information, information regarding charges, or other information which IAP may need in their assessment of this claim.
- 3. I AUTHORIZE IAP 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 DAY of MONTH Year SIGNATURE OF PARENT OR LEGAL GUARDIAN OR INSURED

Attending Physician's Statement - (Must be Completed in Full and Signed by the Attending Physician)

Describe condition: due to: Accident or Illness
Fracture Location & Type and/or
Other Injury Location & Type
Date of onset of symptoms or injury: Did any disease or previous injury contribute to loss? No Yes
If Yes, describe:
First date treated for this condition Date of surgery Was Claimant hospitalized? No Yes
Name of Hospital Date Admitted
Hospital Address Date Discharged
Date: NAME OF PHYSICIAN (please print) Signature of Attending Physician (M.D.)

Please Return To:

Industrial-Alliance Pacific Life Insurance Company, Claims Department, 2165 Broadway W, PO Box 5900, Vancouver, BC V6B 5H6 1-800-556-7411
Important: Completed claim form must be filed with Industrial-Alliance Pacific Life Insurance Company ("IAP") within 90 days after the date of the injury, and in no event later than 1 year, regardless of whether expenses have been incurred. Please attach original receipts for all eligible expenses being claimed. It is the entire responsibility of the parent to obtain and forward the completed claim form as indicated, and for any charge made for its completion.
Medical Injury Claims: The physician must complete the Attending Physician's (M.D.) Statement in order to process the claim. If claim involves physiotherapy or massage therapy expenses a copy of the Physician's referral for the therapy must accompany the completed claim form with receipts.
Dental Injury Claims: The reverse side of this form must be completed and signed by the dentist in order to process the claim.

