



INDUSTRIAL ALLIANCE PACIFIC™
INSURANCE AND FINANCIAL SERVICES™

OUT OF PROVINCE HOSPITAL/MEDICAL INSURANCE CLAIMS INFORMATION SHEET

This document addresses frequently asked questions
related to Out-of-Province Hospital Medical Insurance claims

MEDICAL INJURY / SICKNESS CLAIMS

Important: Hospital/Medical coverage under our policies is "in excess". We are "second payer" over and above Provincial Healthcare plans or any other insurance or plan such as Extended Health or Student Accident insurance and for those covered under the IAP Kids Plus plan, any other travel policy.

- Submit all expenses first to the Provincial Healthcare Plan of your province of residence.
- Send us a copy of the **Statement** you receive from your Provincial Healthcare provider together with the **original receipts** of any bills NOT paid by them.
- The Out-of-Province Insurance Claim form must be completed in full in order to process your claim. Please be sure to state the **departure** and **return** dates and **diagnosis**.
- In the event that the insured was initially seen in a hospital outside Canada, a copy of the *Hospital Discharge Report* must be submitted, if available.
- Claims for **Physiotherapy / Massage Therapy/ Brace expenses** must be accompanied by the original receipts and the written **referral** from the attending physician recommending physiotherapy treatment.
- Please submit the following documents with the **Claim form**:
 1. **Statement** from your Provincial Healthcare Provider.
 2. **Proof of travel:** copies of airline tickets, accommodation receipts, etc. showing your departure and return dates from/to your province of residence.
 3. A copy of your **health card**.
 4. **Original itemized bills:** For prescribed medications only pharmacare receipts will be accepted.
 5. A **copy of your credit card statement** outlining the exchange rate: If expenses were paid for on your credit card.

IMPORTANT

- The Out-of-Province Insurance Claim form must be filed with Industrial-Alliance Pacific Life Insurance Company within 90 days of the date of the injury, regardless of whether expenses have been incurred. Attach only original receipts for all expenses being claimed.
- Please note that it is the responsibility of the claimant to obtain and forward the completed claim form as indicated. *Any charge incurred for its completion is also the responsibility of the claimant.*
- If you have more than one insurance carrier, benefits are coordinated.

WHAT TO EXPECT WHEN YOUR CLAIM IS RECEIVED.....

- Please note that all claims are subject to standard adjudication processing. You should expect a response within 1-3 weeks depending on claims volume. Our response would be one of the following:

- (A) Payment or Notification of Payment to a Provider
- (B) Request for more information if required.
- (C) Acceptance or Denial of the claim with reasons

Return completed claim form to:

INDUSTRIAL-ALLIANCE PACIFIC LIFE INSURANCE COMPANY
Claims Department, 2165 Broadway W, PO Box 5900, Vancouver, BC, V6B 5H6
Tel: 1-800-556-7411
www.iaplifec.com

In providing this claim form 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.

OUT OF PROVINCE HOSPITAL/MEDICAL INSURANCE CLAIM FORM

POLICY NO: 100007783

PLEASE PRINT:

Member's Surname:	Member's Given Name:
Patient's Name:	Relationship to Member:

Street & No.:

Apt./Unit No.: Telephone No.: ()

City/Town: Province: Postal Code:

Patient's Date (dd/mmm/yyyy) of Birth: Patient's Health Card No. and Verification Code:

If insured under the IAP Kids Plus Plan:

Name of School and/or Name of School Board:

Wetaskiwin Regional Public Schools

Grade/Year: School Board No.: 2115

OUT OF PROVINCE TEMPORARY ADDRESS:

1. Departure Date (dd/mmm/yyyy) of planned trip: Return Date (dd/mmm/yyyy): Destination:

2. Mode of Transportation: Reason for Trip:

3. Name and Address of Family Physician:

4. Name and Address of first Physician consulted:

5. Date (dd/mmm/yyyy) of initial onset of illness or injury: Date (dd/mmm/yyyy) of Previous Occurrence or Treatment:

6. Diagnosis:

7. If hospitalized*, advise date of admission: (dd/mmm/yyyy) Discharge Date: (dd/mmm/yyyy)

Name of Hospital: _____

Address: _____

*If available, please enclose a copy of the Hospital Discharge Report.

Please See Reverse

8. If illness, has the patient had this or similar illness before _____
If yes, give dates, name/address of physician _____
9. Was the current treatment due to an emergency? () Yes () No
10. Was the patient advised to seek treatment for this condition in a place other than their normal province of residence?
() Yes () No
If yes, please explain _____

11. Name and address of Employer _____
Employer Phone Number: _____
12. Name of Company who carries your Group Hospital/Medical Insurance or Extended Health Plan.

Policy/Group No. _____ Identification/Certificate No. _____
13. Do you carry any other excess Hospital/Medical or Travel Insurance () Yes () No
If Yes, Name of Company _____
Policy/Group No. _____ Identification/Certificate No. _____
14. Do you have a premium credit card (GOLD CARD) which provides out-of-province medical? If yes, provide details

15. If injuries are the result of an automobile accident, advise name of insurance Company _____
Policy Number: _____ Claim Number: _____
Name/Address of Insured, if other than yourself _____

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 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 that IAP may need in their assessment of this claim.

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 _____ Signed _____
(dd/mm/yyyy) SIGNATURE OF INSURED OR PARENT OR LEGAL GUARDIAN

PLEASE ATTACH ORIGINAL RECEIPTS FOR ALL ELIGIBLE EXPENSES BEING CLAIMED. IT IS THE ENTIRE RESPONSIBILITY OF THE CLAIMANT TO OBTAIN AND FORWARD THE COMPLETED CLAIM FORM AS INDICATED AND FOR ANY CHARGE MADE FOR ITS COMPLETION.