Convalescent Care Plan Claim Form
VICTOR INSURANCE MANAGERS INC.
Policy # 100011855

Claims Procedures

This report is to be completed when you are making a claim for a sickness or injury. You can help us to expedite the handling of your claim by making sure that all questions are answered and by attaching all original receipts or itemized statements, where applicable, for which you are claiming benefits. ***Please return Claim form to 400-988 West Broadway, P.O. Box 5900, Vancouver, BC, V6B 5H6.***

Part A – Claimant's Statement (Please Print)

Surname: Given Names: Certificate Number:

Full Mailing Address: Telephone No.: ( )

1. My claim is a result of: ( ) Accident ( ) Sickness Date of Birth: _____ (DD/MMM/YYYY)

2. Date of Accident/Initial onset of sickness: _____ (DD/MMM/YYYY) Date of Initial Medical Consultation: _____ (DD/MMM/YYYY)

3. Full details of accident:

4. Name and address of attending physician:

5. If hospitalized, provide name and address of hospital: Admission Date _____ (DD/MMM/YYYY) Discharge _____ (DD/MMM/YYYY)

6. If outpatient surgery was performed, please provide name of hospital and type of surgery:

7. a) After discharge from hospital, on what date did you resume your normal daily outdoor activities? _____ (DD/MMM/YYYY)

   b) If you are still confined to your home, when do you expect to resume your daily outdoor activities? _____ (DD/MMM/YYYY)

8. Have you ever had this or a similar condition in the past? If yes, please confirm date and name of treating physician.

9. Indicate which of the following benefits you are claiming. Please attach original receipts or itemized statements.

( ) Convalescent Benefit (following hospitalization) From: _____ (DD/MMM/YYYY) To: _____ (DD/MMM/YYYY)

( ) Convalescent Benefit (following outpatient surgery) From: _____ (DD/MMM/YYYY) To: _____ (DD/MMM/YYYY)

( ) Ambulance/Taxi Benefit (receipts required)
( ) Cataract Surgery Benefit (receipts required)
( ) Comfort Care Benefits (receipts required)
( ) Equipment Benefit (receipts required)
( ) Fracture Indemnity (specify which bones)
( ) Home Nursing Benefit (receipts required)
( ) Patient Transfer Benefit (receipts required)
( ) Physician Validation Expense (receipts required)
( ) Physiotherapy Benefit (receipts required)
( ) Transportation Benefit (to and from hospital or doctor's office; receipts required)
( ) Other (please specify): _____

Medical Authorization

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 Signature: _____ Date: _____ (DD/MMM/YYYY)

Part B – Attending Physician's Statement (Please Print)

Note: *This form has been simplified for your convenience. However, if you wish to complete the standard OMHA approved form, please ask patient to notify the Company.*

Patient's Full Name: _____ _____
Surname Given Names

1. Diagnosis including complications (if fracture, specify bone and show whether complete or not).

2. Date of first consultation regarding this condition: Remained under medical care: _____ (DD/MMM/YYYY)

3. Name of referring physician: Was patient ever previously treated for this or similar situation?
( ) Yes ( ) No If Yes, state when: _____ (DD/MMM/YYYY)

4. If condition caused hospitalization, please provide dates: Date of admission : _____ (DD/MMM/YYYY)
Date of discharge: _____ (DD/MMM/YYYY)

5. If condition required surgery as an outpatient of a hospital, please specify type of surgery:

6. How soon after discharge from hospital would patient have been able to get outdoors unassisted for purposes such as shopping, Visiting, etc.? _____ (DD/MMM/YYYY)

Physicians Name: _____
(Surname) (Given Names)

Physician's Signature: _____(MD) Date: _____ (DD/MMM/YYYY)

Address: _____

PLEASE BE SURE TO HAVE YOUR DOCTOR COMPLETE THIS SIDE