iA Financial Group

Return to:
Life and Health Claims Dept., Special Markets Solutions
2165 Broadway W, PO Box 5900
Vancouver, BC V6B 5H6

Authorization and Declarations for Claims

PROTECTING THE PRIVACY OF YOUR PERSONAL INFORMATION

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 DECLARATIONS

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 by the use of 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 Claimant's Statement 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: _____ Date: _____
(dd/mmm/yyyy)