



ACE INA Insurance
ACE INA Life Insurance

Heath Lambert
Benefits Consulting
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**ACCIDENTAL MEDICAL
CLAIM FORM**

PLEASE COMPLETE ALL DATES IN MONTH/DAY/YEAR FORMAT

Policy No. or Name of University _____

Name		
Date of Birth	Phone # ()	
Address		
City	Province	Postal Code

Name of University	Student No.
Have you previously submitted a claim to ACE INA? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of accident
How did the accident occur?	
What injuries resulted from the accident?	
Date physician first consulted?	
Name and address of physician?	

The above statements are true and correct to the best of my knowledge and belief. I authorize, for a period of not less than twelve (12) and twenty-four (24) months from the date hereof, any physician, practitioner, health care provider, hospital, health care institution, medical organization, clinic and any other medical or medically related facility, insurance company, workers compensation board or similar plan or organization, the plan administrator, federal, territorial or provincial government department, or any other corporation or organization, institution or association, to release and exchange with ACE INA Insurance or ACE INA Life Insurance, or its representatives, all medical or benefit payment information or any other information or records in its possession that the Insurer may request while administrating my claim. I agree that a photocopy of this authorization shall be as valid as the original.

Claimant's Signature _____ Date _____

Are you covered by another Insurance Company for accident? (if so, please advise name of company and provide your policy and certificate numbers)

Date Service Rendered	Nature of Illness	Name of Service Drugs & RX No	Name of Pharmacist	Amount Charged	Name of Doctor Prescribing Service

**IMPORTANT: ALL BILLS AND ORIGINAL PRESCRIPTION DRUG RECEIPTS,
MUST BE ATTACHED TO THIS CLAIM FORM**

Statement of Authority (to be completed by Heath Lambert)

Name of Insured
Policy No.
We certify that the above claimant is insured for the term commencing _____ and ending _____
Date

Signature of Person Authorized by Policyholder _____

Insured's Statement

I hereby certify that the above information is true and correct and that all expenses listed were incurred only by the patient indicated. I understand that ACE INA Insurance or ACE INA Life Insurance may contact my doctor, pharmacist, or any other person and I hereby authorize the release of whatever additional information may be required and that a photocopy of this release shall be deemed as valid as the original.

Date _____

Insured's Signature _____

THIS FORM AND ALL ATTACHMENTS WHICH YOU ARE REQUIRED TO PAY MUST BE FORWARDED WITHOUT DELAY.