RELIABLE LIFE INSURANCE COMPANY

Box 557, 100 King Street West
Hamilton, Ontario L8N 3K9
Toll Free: 800-463-5437
Fax: 866-551-1704

STUDENT ACCIDENT INSURANCE CLAIM FORM

Note: If the insured is a minor, this form should be completed and signed by a parent or guardian.

Part I

Name of School Board	insuremykids® Policy No.
Name of School	Grade
Name of Insured *(Last, First)*	Birthdate *(MM / DD / YY)*
Address *(Street, City, Province, Postal Code)*	
Name of Parent(s)/Guardian(s)	Telephone No.
Employer of Parent(s)/Guardian(s)	

Part II

Did accident occur at school or during school activity? ☐ Yes ☐ No	
Date of Accident *(MM / DD / YY)*	Time of Accident *(Hour)*
Location of Accident	
Nature of Injury	
If taken to hospital, name and address of hospital	
Date and Time of Admittance	Date and Time of Discharge
Name of Attending Physician or Dentist	
Address	Date of first treatment *(MM / DD / YY)*

Part III

Describe fully how the accident occurred	
Name of Witness 1	Address of Witness 1
Name of Witness 2	Address of Witness 2

Part IV

What benefit(s) are you claiming?	Amount Claimed $
Is there coverage under any other insurance or benefit plan (e.g. Group Insurance through your Employer)? ☐ Yes ☐ No If yes, please complete the following:	
Name of Insurance Company / Institution A	Policy No.
Address of Company A	Certificate No.
Name of Insurance Company / Institution B	Policy No.
Address of Company B	Certificate No.

I HEREBY AUTHORIZE any physician, hospital, clinic or other medically related facility, any insurance company, government office or institution or any person or persons, legal or real, to furnish **RELIABLE LIFE INSURANCE COMPANY** with any and all details of my or my child's insurance and medical history. A copy of this authorization shall be valid as the original.

Date *(MM / DD / YY)* _____ Signature _____

CLAIM PROCEDURES

(A) Complete first page of this form FULLY. Please do not submit claims for expenses covered under a Government or other Health Plan.
(B) For claims requiring a report from a Physician, please have a Physician complete the Attending Physician's Statement on the second page of this form.
(C) For claims requiring a report from a Dentist, please have a Dentist complete the Dental Claim form on the third page of this form.
(D) **The company must be notified within 60 days of the date of accident and proof of claim, including a report from the attending Doctor or Dentist, must be submitted within 90 days of the date of the accident.**
(E) This Form and all insured accounts which you are required to pay should be forwarded without delay to the address above.

Please complete this claim form and return it to your patient. *Any charge for completing this form is the patient's responsibility.*

ATTENDING PHYSICIAN'S STATEMENT - TO BE COMPLETED BY THE PHYSICIAN

Patient's Name *(Last, First)*	Age
Address *(Street, City)*	Address *(Province, Postal Code)*
Diagnosis: Please indicate the Name(s) of the bone(s) fractured dislocated:	
If hospitalized, please give name of hospital	
Date Admitted *(MM / DD / YY)*	Date Discharged *(MM / DD / YY)*
If referred to you, please give name of referring Physician:	
If referred by you to another Physician, Physiotherapist, Chiropractor or other practitioner please give name and type of Practitioner:	
OPERATIONS (or other procedures performed)	

1		Date *(MM / DD / YY)*
2		Date *(MM / DD / YY)*
3		Date *(MM / DD / YY)*

Date of first consultation above *(MM / DD / YY)*
Date of first symptom(s) *(MM / DD / YY)*
Date of accident *(MM / DD / YY)*
Has the patient ever had a similar condition? ☐ Yes ☐ No If yes, please state when and describe:
Is there any other disease or infirmity affecting the present condition? ☐ Yes ☐ No If yes, please describe

Name *(Please Print)*	Signature
Date *(MM / DD / YY)*	Certified Specialty
Address *(Street, City, Province, Postal Code)*	
Phone No.	Fax No.