



OLD REPUBLIC

INSURANCE GROUP

RELIABLE LIFE INSURANCE COMPANY

Box 557, 100 King St. W.

Hamilton, ON L8N 3K9

Telephone: (905) 523-6525

(800) 463-KIDS (5437)

Fax: (905) 528-8338

**INSUREMYKIDS®
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 (<i>Last, First</i>)	Birthdate (<i>MM / DD / YY</i>)
Address (<i>Street, City, Province, Postal Code</i>)	
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? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Date of Accident (<i>MM / DD / YY</i>)	Time of Accident (<i>Hour</i>)
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 (<i>MM / DD / YY</i>)

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)? <input type="checkbox"/> Yes <input type="checkbox"/> 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 <i>(Last, First)</i>	
Age	
Address <i>(Street, City)</i>	Address <i>(Province, Postal Code)</i>
Diagnosis: Please indicate the Name(s) of the bone(s) fractured/dislocated:	
If hospitalized, please give name of hospital	
Date Admitted <i>(MM/DD/YY)</i>	Date Discharged <i>(MM/DD/YY)</i>
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 <i>(MM/DD/YY)</i>
2	Date <i>(MM/DD/YY)</i>
3	Date <i>(MM/DD/YY)</i>
Date of first consultation above <i>(MM/DD/YY)</i>	
Date of first symptom(s) <i>(MM/DD/YY)</i>	
Date of accident <i>(MM/DD/YY)</i>	
Has the patient ever had a similar condition? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please state when and describe:	
Is there any other disease or infirmity affecting the present condition? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe	
Name <i>(Please Print)</i>	Signature
Date <i>(MM/DD/YY)</i>	Certified Specialty
Address <i>(Street, City, Province, Postal Code)</i>	
Phone No.	Fax No.



PART 1 DENTIST
UNIQUE NO. SPEC. PATIENTS OFFICE ACCOUNT NO.
I HEREBY ASSIGN MY BENEFITS PAYABLE FROM THIS CLAIM TO THE NAMED DENTIST AND AUTHORIZE PAYMENT TO HIM/HER
P A T I E N T
FIRST NAME LAST NAME
ADDRESS APT.
CITY PROV. POSTAL CODE
D E N T I S T
PHONENQ
SIGNATURE OF SUBSCRIBER

FOR DENTIST USE ONLY - FOR ADDITIONAL INFORMATION, DIAGNOSIS, PROCEDURES, OR SPECIAL CONSIDERATIONS.
I UNDERSTAND THAT THE FEES LISTED IN THIS CLAIM MAY NOT BE COVERED BY OR MAY EXCEED MY PLAN BENEFITS. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO MY DENTIST FOR THE ENTIRE TREATMENT I ACKNOWLEDGE THAT THE TOTAL FEE OF \$ IS ACCURATE AND HAS BEEN CHARGED TO ME FOR SERVICES RENDERED.
I AUTHORIZE RELEASE OF THE INFORMATION CONTAINED IN THIS CLAIM FORM TO MY INSURING COMPANY / PLAN ADMINISTRATOR. I ALSO AUTHORIZE THE COMMUNICATION OF INFORMATION RELATED TO THE COVERAGE OF SERVICES DESCRIBED IN THIS FORM TO THE NAMED DENTIST.
SIGNATURE OF PATIENT (PARENT/GUARDIAN)
OFFICE VERIFICATION

Table with columns: DATE OF SERVICE (DAY, MO, YR), PROCEDURE CODE, INTL. TOOTH CODE, TOOTH SURFACES, DENTIST'S FEE, LABORATORY CHARGE, TOTAL CHARGES

FOR CARRIER USE
ALLOWED AMOUNT, INC, %, PATIENT'S SHARE
CHEQUENQ, DATE
DEDUCTIBLE, PATIENT PAYS, PLAN PAYS
CLAIM NO.

THIS IS AN ACCURATE STATEMENT OF SERVICES PERFORMED AND THE TOTAL FEE DUE AND PAYABLE, E & OE.
TOTAL FEE SUBMITTED

INSTRUCTIONS FOR CLAIM SUBMISSION
BEING A STANDARD FORM, THIS FORM CANNOT INCLUDE SPECIFIC INSTRUCTIONS ON WHERE IT SHOULD BE SENT, DEPENDING ON WHO IS THE CARRIER FOR YOUR PLAN. YOU CAN OBTAIN DETAILS FROM EITHER YOUR PLAN BOOKLET YOUR CERTIFICATE OR FROM YOUR EMPLOYER.
IF YOUR PLAN REQUIRES SUBMISSION DIRECTLY TO THE CARRIER, PLEASE SEND THIS FORM WITH ONLY PARTS 1, 2 AND 3 COMPLETED TO THE CARRIER'S APPROPRIATE CLAIMS OFFICE.
*IF YOUR PLAN REQUIRES SUBMISSION TO YOUR EMPLOYER, PLEASE DIRECT THIS FORM TO YOUR PERSONNEL OFFICE/PLAN ADMINISTRATOR WHO WILL COMPLETE PART 4 AND FORWARD THE FORM TO THE CARRIER.

PART 2 - EMPLOYEE/PLAN MEMBER/SUBSCRIBER
1. GROUP POLICY/PLAN NO. DIVISION/SECTION NO.
2. YOUR NAME (PLEASE PRINT)
EMPLOYER
YOUR CERT. NO. OR S.I.N. OR I.D. NO.
NAME OF INSURING AGENCY OR PLAN
YOUR DATE OF BIRTH DAY MONTH YEAR

PART 3 - PATIENT INFORMATION
1. PATIENT: RELATIONSHIP TO EMPLOYEE/ PLAN MEMBER/SUBSCRIBER
DATE OF BIRTH DAY MONTH YEAR IF CHILD INDICATE: STUDENT HANDICAPPED
IF STUDENT INDICATE SCHOOL
PATIENT I.D. NO.
2. ARE ANY DENTAL BENEFITS OR SERVICES PROVIDED UNDER ANY OTHER GROUP INSURANCE OR DENTAL PLAN, W.C.B. OR GOVT PLAN? NO YES
POLICY NO. SPOUSE DATE OF BIRTH DAY MONTH YEAR
NAME OF OTHER INSURING AGENCY OR PLAN
3. IS ANY TREATMENT REQUIRED AS THE RESULT OF AN ACCIDENT? NO YES
IF YES, GIVE DATE AND DETAILS SEPARATELY.
4. IF DENTURE, CROWN OR BRIDGE, IS THIS INITIAL PLACEMENT? NO YES
GIVE DATE OF PRIOR PLACEMENT AND REASON FOR REPLACEMENT
5. IS ANY TREATMENT REQUIRED FOR ORTHODONTIC PURPOSES? NO YES
6. I AUTHORIZE THE RELEASE OF ANY INFORMATION OR RECORDS REQUESTED IN RESPECT OF THIS CLAIM TO THE INSURER / PLAN ADMINISTRATOR AND CERTIFY THAT THE INFORMATION GIVEN IS TRUE, CORRECT AND COMPLETE TO THE BEST OF MY KNOWLEDGE.
DATE DAY MONTH YEAR
SIGNATURE OF EMPLOYEE/PLAN MEMBER/SUBSCRIBER

PART 4 - POLICY HOLDER/EMPLOYER (FOR COMPLETION ONLY IF APPLICABLE. SEE ABOVE*)
1. DATE COVERAGE COMMENCED
2. DATE DEPENDENT COVERED
3. DATE TERMINATED
4. CONTRACT HOLDER
DATE DAY MONTH YEAR
AUTHORIZED SIGNATURE
(PPOSITION OR TITLE)