## **Claims Administration** OLD REPUBLIC INSURANCE COMPANY OF CANADA RELIABLE LIFE INSURANCE COMPANY

Box 557, 100 King Street West, Hamilton, Ontario L8N 3K9

Toll Free: 888.831.2222 Fax: 866.551.1704

Email: IMKClaims@insuremykids.com

## **INSUREMYKIDS® INSURANCE CLAIM FORM**

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

Part I													
raiti													
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)	(s)/Guardian(s) Email Address												
Primary Phone No.													
Part II													
Did accident occur at school or during school activity?													
Date of Accident (MM / DD / YY)													
Location of Accident	Location of Accident												
Nature of Injury													
If taken to hospital, name and address of hospital													
Date and Time of Admittance	Date and Time of Discharg	ge											
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 1  Name of Witness 2	Address of Witness 1 Address of Witness 2												
Name of Witness 2		Amount Claimed \$											
Name of Witness 2  Part IV	Address of Witness 2	Amount Claimed \$ Yes											
Name of Witness 2  Part IV  What benefit(s) are you claiming?  Is there coverage under any other insurance or benefit plan (e.g. Group Insurance the	Address of Witness 2												
Name of Witness 2  Part IV  What benefit(s) are you claiming?  Is there coverage under any other insurance or benefit plan (e.g. Group Insurance th If yes, please complete the following:	Address of Witness 2	Yes 🗖 No											
Name of Witness 2  Part IV  What benefit(s) are you claiming?  Is there coverage under any other insurance or benefit plan (e.g. Group Insurance th If yes, please complete the following:  Name of Insurance Company / Institution A	Address of Witness 2	Yes  No Policy No.											
Name of Witness 2  Part IV  What benefit(s) are you claiming?  Is there coverage under any other insurance or benefit plan (e.g. Group Insurance th If yes, please complete the following:  Name of Insurance Company / Institution A  Address of Company A	Address of Witness 2	Yes No Policy No. Certificate No.											
Part IV  What benefit(s) are you claiming?  Is there coverage under any other insurance or benefit plan (e.g. Group Insurance th If yes, please complete the following:  Name of Insurance Company / Institution A  Address of Company A  Name of Insurance Company / Institution B  Address of Company B  I HEREBY AUTHORIZE any physician, hospital, clinic or other medically related face	Address of Witness 2  rough your Employer)?	Yes No  Policy No.  Certificate No.  Policy No.  Certificate No.  government office or institution or any person or											
Part IV  What benefit(s) are you claiming?  Is there coverage under any other insurance or benefit plan (e.g. Group Insurance th If yes, please complete the following:  Name of Insurance Company / Institution A  Address of Company A  Name of Insurance Company / Institution B  Address of Company B  I HEREBY AUTHORIZE any physician, hospital, clinic or other medically related fac persons, legal or real, to furnish OLD REPUBLIC INSURANCE COMPANY OF CAN	Address of Witness 2  rough your Employer)?	Yes No  Policy No.  Certificate No.  Policy No.  Certificate No.  government office or institution or any person or											
Part IV  What benefit(s) are you claiming?  Is there coverage under any other insurance or benefit plan (e.g. Group Insurance th If yes, please complete the following:  Name of Insurance Company / Institution A  Address of Company A  Name of Insurance Company / Institution B  Address of Company B  I HEREBY AUTHORIZE any physician, hospital, clinic or other medically related face	Address of Witness 2  rough your Employer)?	Yes No  Policy No.  Certificate No.  Policy No.  Certificate No.  government office or institution or any person or											

- (A) (B) Complete first page of this form FULLY. Please do not submit claims for expenses covered under a Government or other Health Plan.
- 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.
- 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 <b>to you</b> , please give name of referring Physician:									
If insured was referred by you to another legally qualified Practitioner, please indicate Practitioner's specialty and provide the name, telephone number and contact information for same:									
□ Physician □ Physiotherapist □ Chiropractor □ Osteopath □ Other – ple	ease specify:								
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?									
Name (Please Print)	Signature								
Date (MM/DD/YY)	Certified Specialty								
Address (Street, City, Province, Postal Code)									
Phone No.	Fax No.								

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## INSUREMYKIDS® DENTAL CLAIM FORM

	Part 1 Dentist																							
Dentist Information												Patient Information												
Name									Name															
Address								Address																
City	City Province Postal Code							de	City Provi										Posta	Il Code				
Telephone						Telephone																		
Month	Date of Service Int. Procedure Tooth				Tooth					Dentist's Total							For plan administrator use only				1			
MMM	Day DD	Year YYYY	Cod		Code Surfa			Surfaces	faces Charge			9	Fee Charge											
	1		+		+	#																		
	-		+	-	$\vdash$	+											-							
			+		+	-																		
This is	an accur	ate stateme	ont of s	convic					TC	OTAL														
		ees charge			55					JBMIT	TTED	$\rightarrow$	•			Γ								
		Der	ntist's	Signa	ture				-					Da	ate	Month			Year					
For	dentist's	use only. F	or add	litiona	l inforr	mation	re: di	agnosis, p	roce	dure	s, or	compl	icatio	ns, a	nd s	MMM pecial c	onside		ns.					
																			-					
covered	by or may	the fees list y exceed m sponsible to	y polic	y bene	efits. I u	underst	and th	at na					efits payable from this claim to the above authorize payment directly to the dentist.											
I am financially responsible to my dentist for the entire cost of the treatment. I authorize release of the information contained in this claim form to my insuring company or its agents.																								
	Signature of patient (parent/guardian) Signat							gnature	ature of patient (parent/guardian)															
					Pa	rt 2	Dent	ist Sup	ple	me	nta	ry Re	epor	t (m	านร	t be c	comp	lete	ed in fu	II)				
1. Des	Part 2 Dentist Supplementary Report (must be completed in full)  1. Description of damage																							
2. Is further treatment indicated? No  Yes  If "yes" please indicate:  Est. Date - Treatment																								
Int. Tooth Code  Treatment indicated – Use procedure code if possible												Month MMM	Day DD	Year YYYY										
																							- 55	
3 Doo	oribo fu	rthor noto	ntial	aroble		and in	dicat	nd time fr	omo													<u> </u>		
3. Describe further potential problems and indicated time frame																								
Dated	Dated / /																							
Dateu		MON	JTH		′			AY		′ —		YEAR	(4 DI	GITS)		_	_				Dentist's Signa	ature		