Please return to Plan Administrator:

1. If expenses are incurred for a dependent, specify:

Last name _____ First name _____

Relationship to member _____ Date of birth Y M D

Children 21 and over: ❑ Handicapped ❑ Full-time Student Name of school _____

2. If the claim is the result of an accident, specify: ❑ Work ❑ Motor vehicle ❑ Other
and complete the "Dental Care in case of an accident" form (F54-267A)

3. Is any treatment planned for orthodontic purposes? ❑ Yes ❑ No

4. For a denture, crown or bridge, is this an initial placement? ❑ Yes ❑ No IF YES, please submit pre-treatment x-rays.

IF NO, specify date of prior placement Y M D and the necessity for replacement _____

_____

_____

5. For a fixed bridge, have you or do you currently wear a partial denture? ❑ Yes ❑ No

IF YES, specify date of last placement Y M D and the necessity for replacement _____

_____

MEMBER CONFIRMATION/AUTHORIZATION

I HEREBY CONFIRM that the information contained in this Claim Form is true and complete to the best of my knowledge.

If this claim is being made on behalf of my spouse and or/dependent children, **I CONFIRM that I am AUTHORIZED** to disclose information about them with respect to this claim.

On behalf of myself and my dependents:

(1) I consent to the RELEASE of the information contained in this Claim Form to Industrial Alliance, its employees, agents, reinsurers and service providers for the purposes of underwriting, administration and processing of the claim; and

(2) I AUTHORIZE any healthcare provider or professional, medical organization, insurance or reinsurance company, workers' compensation board, the policyholder, my employer, as well as any other person, private or public organization or institution to disclose to Industrial Alliance, its employees, agents and service providers any information regarding the treatment charges incurred which they may need in the assessment of the claim.

I AUTHORIZE the use of my Social Insurance Number as an identification number where it is required for the administration of the group policy.

I AGREE that a photocopy of this Confirmation/Authorization shall be as valid as the original.

Member's signature **X** _____ Date _____

Address _____ Postal Code

Tel. Home ( ) Tel. Work ( )

DISCLOSURE

At Industrial Alliance the personal information we collect concerning you and your insured dependents is kept in strict confidence and is only used for the purposes you have authorized. Your personal file will be kept at Industrial Alliance's offices.

You have the right to request access to your personal information and, if necessary, correct any inaccurate information. In order to do so, send a written request to the following address: Industrial Alliance Insurance and Financial Services Inc., Access Officer, 1080 Saint-Louis Road, Sillery, Quebec, G1K 7M3.

Access to your personal information will be limited to Industrial Alliance's employees, agents, reinsurers and service providers in the performance of their jobs, individuals to whom you have granted access, and persons authorized by law.

For the purposes of audits and administrative reporting, Industrial Alliance may release to your employer/Policyholder statistical financial information without personal identifiers.

Industrial Alliance may establish a list of its insureds to share information within the Industrial Alliance Group. This will help us serve them better and determine whether any products and services that the Industrial Alliance Group offers are suitable so we can offer such products and services to them. However, you are entitled to have your name removed from this list by making a written request to this effect to the Access Officer, as referred to above.