



ACE INA Insurance
 ACE INA Life Insurance
 1400 – 25 York Street
 Toronto, Ontario M5J 2V5
 Telephone: 416-594-2627 1-877-772-7797

CANADIAN ACTORS' EQUITY ASSOCIATION
 CLAIMANT STATEMENT
 MEDICAL CLAIMS
 (ALL MEDICAL CLAIMS EXCEPT
 PARAMEDICAL SERVICES)

PLEASE ENSURE THAT YOU RETAIN COPIES OF ALL RECEIPTS/DOCUMENTATION THAT IS SUBMITTED TO THE INSURANCE COMPANY. ACE INA LIFE INSURANCE WILL NOT BE RETURNING ANY RECEIPTS TO YOU.

PLEASE COMPLETE ALL DATES IN MONTH/DAY/YEAR FORMAT

SCG 100005 Base Plan SCG 102067 Enhanced Plan

Full name of Claimant

Address

City	Province	Postal Code	Phone # ()
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Date of Birth	CAEA Member Number
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Is your membership in good standing and paid up to date? Yes No
 If you respond no, you will need to ensure it is in good standing before submitting this claim.

Name of Production	Start date of Contract
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Last Day of Performance on this Production	Have you previously submitted a claim to ACE INA <input type="checkbox"/> Yes <input type="checkbox"/> No
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Are you covered by another insurance company? If so, please advise name of Company and provide your Policy and Certificate numbers

In case of an accident: Date of the accident	Did the accident happen at work while under contract? <input type="checkbox"/> Yes <input type="checkbox"/> No
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How did it happen?

Briefly describe the role or duties including physical requirements:

**IF YOU ARE CLAIMING REIMBURSEMENT OF MEDICAL SERVICES FOR THE FOLLOWING:
 AMBULANCE OR PRESCRIPTION DRUGS
 PLEASE ATTACH THE ORIGINAL RECEIPTS TO THIS FORM**

OR

**IF YOU ARE CLAIMING REIMBURSEMENT OF MEDICAL SERVICES FOR THE FOLLOWING:
 MEDICAL EQUIPMENT AND SUPPLIES, NURSING, ORTHOTICS, ORTHOPAEDIC SUPPLIES,
 SEMI-PRIVATE ROOM, SPEECH THERAPY, SURGICAL BRA
 PLEASE ATTACH THE ORIGINAL RECEIPTS TO THIS FORM ALONG WITH THE REFERRAL FROM
 YOUR PHYSICIAN OR A COMPLETED CANADIAN ACTORS' EQUITY ASSOCIATION PRACTITIONER
 STATEMENT**

INSURED'S STATEMENT:

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, 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 administering my claim. I agree that a photocopy of this authorization shall be as valid as the original.

Insured's Signature: _____ Date: _____

**PLEASE SUBMIT THIS FORM AND ALL ATTACHMENTS DIRECTLY TO
 ACE INA LIFE INSURANCE.
BEFORE MAILING, PLEASE SEE CHECKLIST ON PAGE 2.**



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CHECKLIST

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Before submitting a completed claim form to ACE INA Life Insurance; please review the attached check list to avoid any delay in the processing of your claim:

- Have you fully completed and signed the appropriate claim form (i.e. medical, paramedical, health and wellness)?
- Is your membership with Canadian Actors Equity Association current and in good standing (fully paid up)?
- Have you attached an official receipt (do not submit a cash register receipt) confirming the type of treatment, date of treatment, name/qualification and signature of the service provider?
- If you are submitting a receipt for a treatment that requires MD referral; have you attached the referral from your medical doctor?
- If you are submitting a massage therapy receipt, did you receive the treatment from a REGISTERED massage therapist?