Desjardins Insurance
LIFE • HEALTH • RETIREMENT

C. P. 3950
Lévis (Québec) G6V 8C6

FINANCIAL SERVICES INCLUDING INSURANCE, ANNUITIES, CREDIT AND RELATED SERVICES

CLAIM FOR HEALTH CARE BENEFITS

SOLO

IMPORTANT INFORMATION

- **To expedite processing of your claim, please answer all questions that apply to your situation and sign section K. Missing or inaccurate information may result in handling delays, and the form may be returned to you for correction.**
- **Send original receipts only (copies will not be accepted). Please keep copies for your records, the originals will not be returned. The explanation of benefits you will receive from us, along with copies of your receipts, are acceptable proof of expense for income tax purposes and coordination of benefits with other carriers.**
- **If your claim is for charges for services provided by a health care professional, please ask him/her to fill out section H.**
- **Claims MUST BE submitted no later than one year after expenses are incurred.**

A - IDENTIFICATION - MANDATORY SECTION

Policy no.	☐ 35000 ☐ 35100 ☐ 35200 ☐ 36000 ☐ 50000 ☐ 700000

Last name and first name of the insured	Sex ☐ M ☐ F	Date of birth YYYY MM DD

Address - Number, street, apartment	City	Province	Postal code

B - COORDINATION OF BENEFITS

The coordination of benefits may entitle you to a reimbursement of up to 100% of your eligible expenses.

HOW TO SUBMIT A CLAIM WHEN THERE ARE TWO INSURERS:

1. The person who has the other insurance coverage must submit a claim to their own insurer first and then provide Desjardins Financial Security Life Assurance Company (DFS) with detailed information about the benefits paid (information found on the explanation of benefits), as well as copies of any receipts.
2. Claims for dependent children must first be submitted under the plan of the parent whose birthday (month and day) comes first in the calendar year.

Last name and first name of person who has the other insurance coverage	Sex ☐ M ☐ F	Date of birth YYYY MM DD

Name of insurer ☐ DFS ☐ Other	Period of coverage YYYY MM DD From / YYYY MM DD To	If the other insurer is DFS : Contract no.:	Certificate no.:

Type of benefits: ☐ Drugs ☐ Dental care ☐ Medical and paramedical care ☐ Vision care ☐ Travel

Type of coverage: ☐ Individual ☐ Couple ☐ Single-parent ☐ Family

Last name and first name of the dependents covered under this other insurance coverage

C - INFORMATION ABOUT DEPENDENTS

For the period in which expenses were incurred.

I confirm that the persons designated below fit the definition of spouse and dependent child as specified in the contract under which this claim has been submitted.
Use one line per person.

CHILDREN AGED 21 OR OLDER
If your child has a functional impairment, please provide us with a medical certificate confirming your child's disability.

Last name and first name	Relation	Sex	Date of birth	Full-time student or with a functional impairment	Name of educational institution attended
	☐ Spouse ☐ Child	☐ M ☐ F	YYYY MM DD	☐ F. time Student YYYY MM DD From / ☐ Funct. Imp. YYYY MM DD To	
	☐ Spouse ☐ Child	☐ M ☐ F	YYYY MM DD	☐ F. time Student YYYY MM DD From / ☐ Funct. Imp. YYYY MM DD To	
	☐ Spouse ☐ Child	☐ M ☐ F	YYYY MM DD	☐ F. time Student YYYY MM DD From / ☐ Funct. Imp. YYYY MM DD To	

D - DIRECT DEPOSIT SERVICE

With this service, your health claim payments are automatically deposited into your bank account. **To enroll in this service**, please attach a specimen cheque marked "VOID" to your claim.

For more details on this service or to make changes to it, please visit our web site at desjardinslifeinsurance.com/planmember.

E - ELECTRONIC NOTICE SERVICE

Available only if you enroll in the direct deposit service (section D).

With this service, you receive an e-mail that gives you access to your explanation of benefits online once your claim has been processed. **To enroll in this service**, please provide your e-mail address:

_____

F - INFORMATION ABOUT THE CLAIM

Is the claim the result of:

• a work injury? ☐ **Yes** ☐ **No** **• a motor vehicle accident?** ☐ **Yes** ☐ **No**

If yes: • Please note that the claim must first be submitted under your provincial workers' compensation plan or automobile insurance plan (if applicable in your province) before being submitted to your group plan.

• Name of injured person: Date of accident: YYYY MM DD

G - INFORMATION ABOUT DRUG EXPENSES **If you have this benefit.**

- Attach your prescription drug receipts to this form.
- All receipts must contain the drug identification number (DIN) and the name of the drug.
- If DFS requires further information, please ask your attending physician to fill out the following section:

Name of the patient	Name of drug	Diagnosis	Signature of physician

H - INFORMATION ABOUT MEDICAL/PARAMEDICAL EXPENSES (e.g.: chiropractor, massage therapist, physiotherapist)

If a medical recommendation is required under the terms of your policy (please consult your booklet if you are unsure), please include it.

Please attach an itemized statement or a receipt stating:

- patient's name
- practitioner's name
- practitioner's licence or registration number
- type of practitioner
- length of visit
- date(s) of visit(s)
- charge for each treatment
- date at which the patient reached the maximum payable by province's health plan (if applicable)

Please ask the health care professional to fill out the following section:

Name of the patient	Type of practitioner	Health problem	Signature of practitioner

If for psychotherapy, please indicate the type: ☐ Individual ☐ Family ☐ Group ☐ Marriage

I - OUT-OF-PROVINCE EXPENSES

Please include the original receipt itemizing all of your out-of-province expenses.

Length of trip: From _____ (YYYY MM DD) To _____ (YYYY MM DD) Destination: _____ Amount claimed: $ _____

Reason for trip: ☐ Pleasure ☐ Business ☐ Receive care (please ensure that this type of trip is covered by your policy)

J - PERSONAL INFORMATION MANAGEMENT

Desjardins Financial Security Life Assurance Company (DFS) handles the personal information it has on you in a confidential manner. DFS keeps this information on file so that you may benefit from the Company's various financial services (insurance, annuities, credit, etc.). This information is consulted solely by DFS employees who need to do so in the course of their work. You have the right to consult your file. You may also have information corrected if you demonstrate that it is inaccurate, incomplete, ambiguous or not useful. To do so, you must send a written request to the following address: Privacy Officer, Desjardins Financial Security Life Assurance Company, 200, rue des Commandeurs, Lévis, Québec, G6V 6R2. DFS may send information on its promotions or offer new products to those whose names appear on its client list. If you do not wish to receive these offers, you may have your name removed from the list. To do so, you must send a written request to the Privacy Officer at DFS.

K - DECLARATION AND AUTHORIZATION FOR THE COLLECTION AND COMMUNICATION OF PERSONAL INFORMATION

All the information I have provided on the claim form is accurate and complete. I acknowledge having read the Personal Information Management section. I authorize Desjardins Financial Security Life Assurance Company, strictly for the purposes of managing my file and settling this claim to: (a) collect from any person or legal entity, or from any public or parapublic organization, only the information deemed necessary to manage my file. The non-exhaustive list of sources from which information may be collected includes health care professionals or facilities, insurance companies; (b) communicate to the said persons or organizations only the personal information about me that is deemed necessary for the purposes of my file; (c) when necessary use the personal information it may have about me in existing files that are now closed.

This authorization is also valid for the collection, use and communication of personal information concerning my dependents, insofar as applicable to the claim. A photocopy of this authorization is as valid as the original.

Signature of the insured _____ **Date** _____

Telephone nos: Home: ( ) - Office: ( ) - Extension:

Please send to: Desjardins Financial Security Life Assurance Company, C. P. 3950, Lévis (Québec) G6V 8C6

PRINT NEW REQUEST