Desjardins Insurance
LIFE • HEALTH • RETIREMENT

C. P. 3950
Lévis (Québec) G6V 8C6

GROUP INSURANCE - HEALTH CLAIMS

CLAIM FOR HEALTH CARE BENEFITS

TO EXPEDITE PROCESSING OF YOUR CLAIM, PLEASE ANSWER ALL QUESTIONS.

A - IDENTIFICATION

Policy or group or contract no.	Certificate no.	**IF GROUP IS SELF-ADMINISTERED the administrator must complete this section before the member fills out the form**
Member's last name and first name	Sex ☐ M ☐ F — Date of birth YYYY MM DD	**In force** — Individual YYYY MM DD; Family YYYY MM DD; Other, specify YYYY MM DD
Number, street, apartment		**Terminated** YYYY MM DD
City — Province — Postal code		**Administrator's signature**
Name of group or policyholder or employer		**Date**

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 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 — From YYYY MM DD to YYYY MM DD

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 (use one line per person).

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.

CHILDREN AGED 18 OR 21 OR OLDER (depending on the policy). If your child has a functional impairment, please provide us with a medical certificate confirming your child's disability.

Last name	First name	Relationship	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 Stud. ☐ Funct. Imp. YYYY MM DD From To	
		☐ Spouse ☐ Child	☐ M ☐ F	YYYY MM DD	☐ F. time Stud. ☐ Funct. Imp. YYYY MM DD From To	
		☐ Spouse ☐ Child	☐ M ☐ F	YYYY MM DD	☐ F. time Stud. ☐ Funct. Imp. YYYY MM DD From To	

In the case of a change of spouse, please indicate:
☐ Start date of cohabitation: YYYY MM DD OR ☐ Date of marriage: YYYY MM DD
Child born of this union? ☐ No ☐ Yes → Date of birth: YYYY MM DD

D - HEALTH SPENDING ACCOUNT - If you have this coverage, check the options you would like.

- I confirm that I am eligible for a reimbursement of the indicated expenses under my Health Spending Account.
- I recognize that I am responsible for paying any taxes that may result from the reimbursement of these expenses.
- I recognize that for tax or administrative purposes, my plan administrator may have access to a statement of expenses for which I claimed a reimbursement under my Health Spending Account.

☐ **1.** I do not wish to use my Health Spending Account.

☐ **2. Ineligible expenses -** I wish to use my Health Spending Account to cover the expenses that are not reimbursed under my group insurance.

☐ **3. Spouse's family coverage -** I wish to use my Health Spending Account for myself and my dependent children to cover the expenses that are not reimbursed under my group insurance. I will not submit a claim to my spouse's insurer (coordination of benefits).

IMPORTANT INFORMATION

- **Attach your original receipts to this form and keep copies for your files. The original copies will not be returned. Your explanation of benefits and the copies of your receipts are sufficient for income tax and coordination of benefit purposes.**
- **Claims MUST BE submitted no later than twelve months after expenses are incurred.**

E - DIRECT DEPOSIT AND ELECTRONIC NOTICE SERVICE

With these services, your health claim payments are automatically deposited into your bank account, and you receive an email that gives you access to your explanation of benefits online once your claim has been processed.

☐ I would like to enroll in the Direct Deposit Service and Electronic Notice Service.
To enroll in this service, please attach a specimen cheque marked "VOID" and provide your e-mail address:

_____

☐ I would like to enroll in the Direct Deposit Service, but I do not wish to receive any e-mail notices.

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

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 - 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)

H - 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 group insurance services offered by the Company. 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 use the client list to offer its clients an insurance product following the termination of their group insurance. 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.

I - 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 member _____ **Date** _____

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

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

100%

PRINT NEW REQUEST