Desjardins Insurance
Life • Health • Retirement

200, rue des Commandeurs
Lévis (Québec) G6V 6R2
www.desjardinslifeinsurance.com

Claim
Accirance

Instructions

If you're making a claim for:

A fracture: Complete sections A, B and E, and attach a copy of the radiology report.

A hospitalization, disability,[1] loss of use, dismemberment or coma:[2]
Complete sections A, B, E and F.

Any other reason, except for death: Complete sections A, B and E, and attach medical confirmation of the injury.

Death: This isn't the form you need to complete. Call us at **1-877-886-5042**.

[1] For students aged 16 to 24 inclusive.
[2] For Accirance Select contracts only.

After you've completed the form

Sign it and send it online or by mail:

Online
www.desjardinslifeinsurance.com/send

Mail
Desjardins Insurance
200, rue des Commandeurs
Lévis (Québec) G6V 6R2

Questions?

Call us at **1-877-886-5042**
(Monday to Friday from 8:00 a.m. to 5:00 p.m.)

What you also need to know

- To receive your payment by **direct deposit**, please send us a void cheque.
- We may ask you for more information.
- If you provide documents, we won't send them back to you unless you ask.

A. About you (the contract holder)

Last name	First name	Contract number	
Address – Number, street and apartment	City	Province or territory	Postal code

B. Contract holder's statement

1. About the injured person

Last name	First name	Date of birth (YYYY-MM-DD)	Age	Sex ☐F ☐M

Does the injured person have other accident coverage (group, individual or government)?
☐ Yes ☐ No **If Yes**, please provide the information below.

☐ Group insurance →	Name of insurer	Contract number	Certificate number
☐ Individual insurance →	Name of insurer	Contract or policy number	
☐ Government insurance →	Name of government agency		

If student, provide name of school

2. About the accident

Date (YYYY-MM-DD)	Time ☐AM ☐PM	Place

Detailed description (type of accident and circumstances) – If there isn't enough space, use a separate sheet of paper, and be sure to sign and date it.

Nature of injuries – If it's a fracture, please specify whether it involves the larynx, the trachea or a bone (indicate which bone).

Was the injured person hospitalized? ☐Yes ☐No **If Yes** →	Dates (YYYY-MM-DD) From:	To:	Name of hospital

Names and addresses of doctors

⚠ Please sign the last page of this form

C. Consent related to the management of your personal information by Desjardins Group

This consent applies to the contract holder and the injured person.

1. Management of your personal information	To serve you on a daily basis and meet our legal obligations, we need to collect, use and disclose information about you. For more details, see Desjardins Group's Privacy Policy at www.desjardins.com/privacy-policy. You may be asked for specific consent to ensure that Desjardins Insurance can deliver or continue to deliver service. This will be done in compliance with Desjardins Group's Privacy Policy. Desjardins Insurance handles all your personal information confidentially. Your information will be accessed only by employees who require it to complete their tasks.
2. Your rights	You can: • See the personal information Desjardins Group has about you • Correct any information that's incomplete, ambiguous or not relevant To find out how, see Desjardins Group's Privacy Policy.
3. Collection or transfer of your personal information outside of Canada	Desjardins Insurance uses service providers located outside of Canada to perform certain specific activities in its normal course of business. As such, personal information may be collected in and/or transferred to another country and be subject to the laws of that country. For information about our policies and practices regarding the collection and transfer of personal information outside of Canada, see Desjardins Group's Privacy Policy. You can also obtain this information, or ask any questions you might have, by calling us a 1-800-463-7870.

By signing this form, you:

- Acknowledge that you've looked at Desjardins Group's Privacy Policy, which is available at www.desjardins.com/privacy-policy
- Authorize Desjardins Group to collect, use and disclose your personal information based on the conditions outlined in the policy and applicable regulations
- Acknowledge and accept that this consent takes precedence over any other consent you've previously signed
- Acknowledge that this consent remains valid for as long as you have a business relationship with a Desjardins Group component

⚠ Please sign the last page of this form

D. Consent related to the management of your personal information by Desjardins Insurance

This consent applies only to the injured person.

1. Why Desjardins Insurance needs your consent

Your consent allows us to collect, use and disclose the personal information we require to:

1. Analyze your insurance applications
2. Manage your file while you're covered under the insurance
3. Process claims

Your consent also allows us to do the following, as required:

- Look at information in any old insurance file you may have with Desjardins Insurance
- Ask a personal information broker to provide us with an investigation report about you, if necessary
- Send a summary of your personal information, including health-related information, to MIB, LLC (see text box below), after analyzing an insurance application you've submitted

  MIB, LLC is an organization that operates a database allowing insurance companies in Canada and the United States to collect and disclose information about their clients.
- Send your doctor any medical information that we obtained about you when analyzing your insurance applications or claims, so they can share it with you
- Provide insurers and reinsurers with any relevant information (medical test results, etc.), so they can assess an insurance application you've submitted

By giving your consent to us, you also authorize our reinsurers to collect, use and disclose your personal information the same way we would. Our reinsurers are companies that insure us, Desjardins Insurance.

2. Who your personal information will be collected from or disclosed to	You give your consent for the collection and disclosure of the necessary information with you, but also with other people and organizations. These people and organizations include: • MIB, LLC • Healthcare professionals or establishments (doctors, hospitals, clinics, etc.) • Healthcare providers • Paramedical firms • Public or parapublic organizations • Insurance companies other than Desjardins Insurance • Reinsurers • Your employer or a former employer • The policyowner (also called policyholder or contract holder), if you aren't that person • Other Desjardins components, if they're involved in the insurance • A personal information broker or an investigation firm
3. If the application concerns your children	You authorize us to collect, use and disclose the necessary information about them, if they're under age 14 (Quebec) or under age 16 (all other provinces and territories).

By signing this form, you:

- Authorize Desjardins Insurance and its reinsurers to collect, use and disclose your personal information based on the conditions outlined in this section, the applicable regulations and Desjardins Group's Privacy Policy. You can consult the policy at www.desjardins.com/privacy-policy
- Declare that the information you have provided here is complete and accurate

E. Signatures

x _____ Signature of the contract holder

_____ Date (YYYY-MM-DD)

x _____ Signature of the injured person

_____ Date (YYYY-MM-DD)

› If the person is a minor child who is under age 14 (Quebec) or under age 16 (all other provinces and territories), a parent, guardian or legal representative must sign for them and complete the green box below

Person signing for the minor child:

_____
First and last names (please print)

Relationship to the minor child:

☐ Parent (father or mother) ☐ Guardian (Quebec)

☐ Legal representative (all provinces and territories other than Quebec)

F. Doctor's statement – You don't need to have this section completed if you're submitting a claim for a fracture only.

⚠ You're responsible for paying any fees the doctor may charge to complete it.

Date of first visit (YYYY-MM-DD)	Injury diagnosis

If the injured person was hospitalized

Admission			Discharge		
Date (YYYY-MM-DD):	Time:	☐ AM ☐ PM	Date (YYYY-MM-DD):	Time:	☐ AM ☐ PM

If the injured person was disabled

Cause	Period (YYYY-MM-DD)	
	From:	To:

Is the accident described in **section B** the reason for the: → Hospitalization? ☐ Yes ☐ No Disability? ☐ Yes ☐ No

Doctor's name and address (please print)

x _____ Doctor's signature

_____ Date (YYYY-MM-DD)

Print Reset