Desjardins Insurance
Life • Health • Retirement

Case postale 3800
Lévis (Québec) G6V 0S1
www.desjardinslifeinsurance.com/send

Claim
Total Long-term Care

Independent Living
Loss-of-independence
Long-term Care Advance
Accelerated Independence

If you have any questions, please call us at 1-866-850-7198.

Instructions

- This form must be completed by the insured person and the policyholder (if other than the insured person). An authorized representative of the insured person may also complete the claim if the latter is incapable of doing so.
- If you are acting as the authorized representative of the insured and you file a claim on his or her behalf, please provide the document giving you the legal authorization to do so (e.g., power of attorney, documents pertaining to a guardianship or mandate in case of incapacity).
- Be sure to complete all of the pages of this form and sign the “Authorization to collect and communicate personal information”.
- Complete the “Identification of the insured person” section of the Attending Physician’s Statement, and have your attending physician or the physician who is most familiar with your current health condition complete both pages of this section.
- Please provide us with a copy of your attending physician’s medical records and any other information from healthcare professionals (such as a social worker or practical nurse) with a licence to practise in Canada or the United States.
- When all of the sections of this form have been completed and signed, please return it to us:

Submit online:

www.desjardinslifeinsurance.com/send

Complete and save the form on your computer first.
Keep original forms for your records.

By mail:

Desjardins Insurance
C.P. 3800
Lévis (Québec) G6V 0S1

Send original forms and keep copies for your records.

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Insured Person's Statement

Name of the person filing the claim (if other than the insured person)

Relationship with the insured person	10-digit phone number

A. Identification of the insured person

Last name	First name	Sex ☐ M ☐ F	Policy number

Address – No., street, apt.	City

Province or territory	Postal code	10-digit phone number	Date of birth (YYYY-MM-DD)

B. Place of residence

Do you currently live at the address above? ☐ Yes ☐ No

If yes, who lives with you? ☐ alone ☐ spouse ☐ family member ☐ other

If no, where do you live at present? ☐ in a care facility ☐ in a hospital ☐ at a family member's home ☐ other

C. Power of attorney and guardianship

Have you given a power of attorney or are you subject to a guardianship? ☐ Yes (please provide a copy of the related documents) ☐ No

Name of the person holding the power of attorney or the legal guardian

Address – No., street, apt.

City	Province or territory	Postal code

10-digit phone numbers	Home	Work	Ext.

D. Care

Please describe the health problem that triggered your loss of independence and provide the date on which you first requested assistance due to this condition.

Please provide the names of all of the physicians you consulted regarding this health problem:

Name	Address	10-digit phone number	Date last consulted (YYYY-MM-DD)

If you were recently hospitalized or stayed at a care facility, please provide the information below.

Name	Address and 10-digit phone number	Date of admission (YYYY-MM-DD)	Date of discharge (YYYY-MM-DD)

Please provide the names of everyone who provides you with care or assistance, such as an authorized health care provider, friends and family members.

Name of the agency or person who provides you with care or assistance	Is this person an authorized health care professional?	Adress	10-digit phone number	Start date of care or assistance (YYYY-MM-DD)	Description of the assistance or care provided
	☐ Yes ☐ No				
	☐ Yes ☐ No				
	☐ Yes ☐ No				
	☐ Yes ☐ No				

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

This consent applies to the policyowner and the insured 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 next page of this form

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

This consent applies only to the insured 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, 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 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

G. Signatures

x _____ _____

Signature of policyowner | Date (YYYY-MM-DD)

x _____ _____

Signature of insured 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)

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Request for Medical Information

Instructions

The insured person or his/her authorized representative must complete this page before giving all of the necessary forms to the physician.

The insured person is responsible for the securing of this form and any charge which may be made for its completion.

Identification of the patient

Last name of the insured person	First name	Policy number

Address – No., street, apt.

City	Province or territory	Postal code

10-digit phone number	Date of birth (YYYY-MM-DD)

Print **Reset**

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Physician's instructions

Please provide complete and accurate answers to all of the questions and return the form to the patient. This medical information will be used to assess the patient's eligibility for long-term care benefits.

ⓘ **Fees charged for this statement are to be paid by the insured person.**

A. Identification of the insured person

Last name of the insured person	First name	Sex ☐ M ☐ F
Date of birth (YYYY-MM-DD)	Policy number	

B. State of health

1. What health problems have been diagnosed for the insured person?

Principal diagnosis: _____ Onset of symptoms (YYYY-MM-DD): _____

Secondary diagnosis: _____ Onset of symptoms (YYYY-MM-DD): _____

Trigger for diagnosis (accident, suicide attempt, drugs, alcohol, etc.):

_____

2. When was the patient's last visit? (YYYY-MM-DD) _____

What was the reason for his/her last visit (primary problem)? _____

C. Activities of daily living

ⓘ **To the physician**: Please answer questions 3, 4 and 5 based on the following definitions of activities of daily living (ADLs).

Bathing: the ability to wash oneself in a tub, shower or by sponge bath, with or without the aid of equipment.

Dressing: the ability to put on or take off garments and/or braces, artificial limbs or other surgical prosthetic devices.

Toileting: the ability to do all of the following, with or without the aid of equipment: (a) get to and from the toilet; (b) get on and off the toilet, and (c) perform associated personal hygiene.

Transferring: the ability to: get in and out of a chair (including a wheelchair) or bed. If a person can move with the help of equipment such as a cane, walker, crutches, grab bars or other support devices, then he or she will be considered able to transfer positions.

Continence: the ability to maintain control of bowel or bladder function; or, when unable to maintain such control, the ability to perform associated personal hygiene (including caring for a catheter or colostomy bag).

Eating: the ability to consume food that has already been prepared and made available, with or without adaptive utensils.

3. Please indicate the degree of assistance required by the patient to perform the ADLs described above. Check only one box for each of these activities to specify the patient's current capacity level.

Activities of daily living (ADLs)	The patient requires no assistance and performs the activity independently	The patient requires some assistance or supervision (close proximity) each time he/she performs the activity	The patient requires the direct physical assistance of another person to perform the activity
Bathing			
Dressing			
Toileting			
Transferring			
Continence			
Eating			

4. On what date did the patient first require some supervision or the direct physical assistance of another person to perform one of these activities? (YYYY-MM-DD)

5. Please provide any additional information regarding the patient's ability to perform these activities.

D. Cognitive impairment

To the physician: Please answer questions 6 and 7 based on the following definition of cognitive impairment.

Cognitive Impairment: a loss of mental capacity demonstrated by a person's inability to think, perceive, reason or remember. Such impairment (a) results in the insured person's inability to care him or herself without ongoing supervision from another person; and (b) is due to a mental condition with an organic cause. Determination of cognitive impairment will be made on the basis of clinical data and valid standardized measure of such impairments.

6. Has the patient been diagnosed with a cognitive impairment? ☐ Yes ☐ No

If you answered no, please move on to question 7.

If yes, please provide the diagnosis: _____

Date of onset of the impairment (YYYY-MM-DD): _____

Diagnostic tests performed:

1. _____

2. _____

Check one of the following to specify the patient's degree of cognitive impairment:

☐ The patient has a mild cognitive impairment and does not require constant supervision.

☐ The patient has a serious cognitive impairment; he/she requires constant supervision as well as reminders to protect his/her health and safety.

7. If you have any additional information about the patient's impairment, please include it below.

E. Identification of physician

Name of the physician completing the form		Licence number		
Address – No., street, office		City	Province or territory	Postal code
10-digit phone number	10-digit fax number	Indicate whether you are the patient's attending physician or a specialist ☐ Attending physician ☐ Specialist		

X _____ _____

Signature of physician | Date (YYYY-MM-DD)

If you have any questions, please call Claims Administration at 1-866-850-7198.