Desjardins Insurance
Life • Health • Retirement

200, rue des Commandeurs
Lévis (Québec) G6V 6R2
1 877 938-8191

Claim
Employer's Statement

Once you've signed and completed both sections, please send us the form using one of the options below :

Online:

www.desjardinslifeinsurance.com/send

(Complete and save the form on your computer first.)

By mail:

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

Send the original and keep a copy for your records.

⚠ We cannot settle this claim unless all questions are answered adequately.

☐ Death of Employee/Plan Member ☐ Death of a Dependent ☐ Accidental Dismemberment or Loss ☐ Critical Illness

Type of claim

☐ Basic Life Insurance Amount: _____

☐ Dependent Life Insurance Amount: _____

☐ Optional Life Insurance Amount: _____

☐ Basic Accidental Death and Dismemberment Insurance Amount: _____

☐ Optional Accidental Death and Dismemberment Insurance Amount: _____

☐ Critical Illness Insurance Amount: _____

☐ Other, please specify: _____ Amount: _____

Contract/Group No.	Account/Division No.	Class	Identification/Certificate No.

A. Identification of employee

Last name	First name	Date of birth (YYYY-MM-DD)

B. Identification of individual concerned (if other than the employee)

Last name	First name	Date of birth (YYYY-MM-DD)

C. Identification of employer

Name of employer

Address – No., Street

City	Province	Postal code

10-digit telephone No.

Extension:

D. Employer's statement

1. Employee hire date (YYYY-MM-DD)	2. Coverage effective date (YYYY-MM-DD)	3. Number of hours worked per week

4. Occupation

5. Was the employee at work on the date the event took place? ☐ Yes ☐ No

If **No**, please specify:

a) Reason for the absence

☐ Disability/Sick leave ☐ Layoff ☐ Leave of absence ☐ Other, please specify: _____

b) Last day actively at work (YYYY-MM-DD)

_____

6. Salary on last day actively at work	7. Salary at time of death or loss

8. If this is a death claim, proceeds should be sent to:

☐ Employer ☐ Beneficiary ☐ Other, please specify: _____

9. Comments

E. Declaration

I declare that the information provided above is complete and true.

_____ _____

Name of employer's representative (please print) Title

X _____ _____

Signature of employer's representative Date (YYYY-MM-DD)

Print **Reset**