Desjardins Insurance
Life • Health • Retirement

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1-800-263-1810

CLAIM – CONVALESCENT CARE

Section A. General information (to be completed by the member)

Last name and first name of member | Date of birth YYYY MM DD | Policy or group or contract No.

Address: No., street, apartment | City | Province | Postal code | Certificate No.

Name of the person for whom expenses were incurred | Relationship to member | Date of birth YYYY MM DD

Name of group or policyholder or employer | **Signature of administrator (if required)** | **Date** YYYY MM DD

1. Type of event (check the corresponding event(s)) ☐ Hospitalization ☐ Surgery — Date of event YYYY MM DD
2. Describe the circumstances that led to the hospitalization, surgery or accident:
3. Are the claimed benefits covered under another insurance contract? ☐ Yes ☐ No
   If yes: Name of insurer: ______ Contract No.: ______
4. Was Assistel contacted before services were received? ☐ Yes ☐ No If yes, file No.: ______

IMPORTANT: IF YOUR RETURN TO WORK IS ANTICIPATED, PLEASE ADVISE THE INSURER ON THE RETURN DATE.

Section B. Personal information management

To serve you effectively every day and fulfill our legal obligations, we need to collect, use and disclose information about you. You can read Desjardins Group's Privacy Policy at www.desjardins.com/privacy-policy for full details on how your personal information is processed. Specific consents may be required to begin and maintain a business relationship with Desjardins Financial Security Life Assurance Company, hereinafter Desjardins Insurance. These steps will be taken in compliance with Desjardins Group's Privacy Policy. Desjardins Insurance handles the personal information it has on you in a confidential manner. Access to your file is limited to authorized personnel who need it to access it to perform their duties. Desjardins Insurance may also communicate with plan members to provide them with optimal health management (management claim tools, informative health documentations, etc.) and offer its clients an insurance product following the termination of their group insurance. You have the right to review your personal information in our files and correct anything that is incomplete, ambiguous or not relevant.
To do so, please consult our Privacy Policy.

Section C. Declaration and authorization for the collection, use 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 Insurance 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 healthcare 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. To achieve the purposes described above and to provide you support, your information, on a depersonalized basis, may be used for analysis, statistics and development of predictive models. 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 member ______ **Date** ______

Telephone Nos.: Home: ______ Office: ______ Extension: ______

Section D. Convalescence period (to be completed by the attending physician who prescribed the convalescence)

1. Diagnosis: ______
2. Treatment or type of surgery: ______
3. Hospitalization: Admission date: YYYY MM DD ______ Discharge date: YYYY MM DD ______
   Name of hospital: ______
4. Check the loss of autonomy criteria justifying a period of convalescence:
   - ☐ Eating - The insured person needs assistance in preparing meals or feeding himself.
   - ☐ Moving - The insured person needs assistance in getting out of a bed or a chair, lying down or sitting.
   - ☐ Dressing - The insured person needs assistance in putting on or taking off his clothes and his orthopedic prosthesis.
   - ☐ Taking care of basic hygiene needs - The insured person needs assistance in washing, getting in or out of the bathtub or shower or using the toilet.
5. Period of prescribed convalescence: period during which the insured person must necessarily present one or more loss of autonomy criteria listed above:
   From YYYY MM DD ______ To YYYY MM DD ______ Number of days: ______
6. Did you recommend home nursing care? ☐ Yes ☐ No If yes, for which type of services? ______
7. Did the insured person previously consult you or another professional for the condition requiring hospitalization or sugery before YYYY MM DD ______? ☐ Yes ☐ No
   If yes, please provide the following information:

Name of attending physician	Date of visits	Diagnosis	Treatments
	YYYY MM DD		
	YYYY MM DD		
	YYYY MM DD		

8. Was the convalescence prescribed following a delivery? ☐ Yes ☐ No
   If yes, was the insured person hospitalized at your recommendation for more than seven (7) days **after** delivery due to complications?
   ☐ Yes ☐ No If yes, please indicate the:
   a) Number of days in hospital (after delivery): ______ days
   b) Details of complications : ______

Name and address of the attending physician (PLEASE PRINT)

Licence No.: ______

Telephone No.: ______

Signature of attending physician: ______ **Date:** ______

For all benefits claimed: 1. You must submit the original receipt which includes all details of services rendered.
2. When the space available is not sufficient, you may attach a separate sheet which you must date and sign.

Section E. Domestic assistance services (to be completed by the insured person or by the member)

Date of services YYYY MM DD	Details of services	Number of days	Fees per day
			$
			$
			$

Name of provider:

Address:

Telephone No.:

Relationship to member: ☐ Friend ☐ Family member ☐ Other, please specify:

Section F. Home nursing care (to be completed by the insured person or by the member)

What services were provided?	Date of services YYYY MM DD	Hourly rate	Number of hours	Amount
				$
				$
				$

Name of the nurse:

Address:

Licence No.: Telephone No.:

Relationship to member: ☐ Friend ☐ Family member ☐ Other, please specify:

Section G. Stay in a convalescent facility (to be completed by the insured person, by the member or by the convalescent facility)

Name and address of the convalescent facility

Duration of stay: From: YYYY MM DD To: YYYY MM DD Amount: $

Section H. Custodial services (to be completed by the insured person or by the member)

Date of services YYYY MM DD	Name of child	Date of birth YYYY MM DD	Amount claimed	Amount normally paid for child care
			$	$
			$	$
			$	$

Name of baby-sitter:

Address:

Telephone No.:

Relationship to member: ☐ Friend ☐ Family member ☐ Other, please specify:

Section I. Transportation expenses (to be completed by the insured person or by the member and signed by each physician or health care professional consulted)

Only eligible following surgery or hospitalization.

Dates YYYY / MM / DD	Round-trip transportation used	Care provided		Name, address and licence No. of physician or health care professional
	$ Taxi km Private car $ Parking $ Public transit		**Signature of physician or health care professional**	
	$ Taxi km Private car $ Parking $ Public transit		**Signature of physician or health care professional**	
	$ Taxi km Private car $ Parking $ Public transit		**Signature of physician or health care professional**	