Desjardins Insurance
Life • Health • Retirement

C. P. 3950
Lévis (Québec) G6V 8C6
desjardinslifeinsurance.com/planmember
1-800-278-0669

CLAIM FOR DENTAL CARE EXPENSES SOLO

SECTION A. DENTIST INFORMATION

Last name and first name | Member number | Telephone number

Address – No., street, suite | City | Province | Postal code

SECTION B. CLAIM INFORMATION

IMPORTANT: If the claim is for dental treatment due to an accident, a crown, veneer application, inlay or denture, please refer to sections I and J.
If the treatment requires more than one session, the date of treatment must be the date on which the treatment terminates or the insertion date.

Last name and first name of the patient | Date of birth YYYY MM DD | Relationship to the policyowner ☐ Spouse ☐ Child

Treatment date YY MM DD	Tooth No.	Procedure code	Tooth surface	Laboratory expenses	Dentist's fees	Total charge

Total fee claimed:

Diagnosis – This section is reserved for the dentist:

THIS IS AN ACCURATE STATEMENT OF SERVICES PERFORMED AND FEES CHARGED.

Signature of dentist: Date:

SECTION C. ASSIGNMENT OF BENEFITS

I hereby assign benefits payable from this claim to the above named dentist and authorize Desjardins Financial Security Life Assurance Company, hereinafter Desjardins Insurance, to pay the dentist directly.

Signature of insured: **Date:**

SECTION D. INSURED INFORMATION – To be completed by the insured. To expedite processing of your claim, please answer all questions.

Policy No. ☐ 35000 ☐ 35100 ☐ 35200 ☐ 36000 ☐ 37000 ☐ 50000 ☐ 700000

Insured's last name and first name | Date of birth YYYY MM DD

Address – No., street, apartment | City | Province | Postal code

Complete only if you are claiming expenses incurred for your dependent children aged 21 or older. Remember to include the information for the period in which the expenses were incurred for your child. If your child has a functional impairment, please provide us with a medical certificate confirming your child's disability.

☐ Has a functional impairment

☐ Full-time student – Name of educational institution attended: Period: From YYYY MM DD To YYYY MM DD

SECTION E. COORDINATION OF BENEFITS – To be completed by the insured.

Last name and first name of person who has the other insurance plan | Date of birth YYYY MM DD

Name of insurer ☐ Other ☐ Desjardins Insurance – Contract No.: Certificate No.:

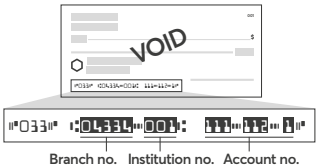
Period of coverage YYYY MM DD From YYYY MM DD To

Type of dental coverage: ☐ Individual ☐ Couple ☐ Single-parent ☐ Family

Last name and first name of the dependents covered under this other insurance plan

SECTION F. DIRECT DEPOSIT SERVICE – Attach a void cheque or provide your bank information below to sign up for direct deposit.

Transit/branch No. | Institution No. | Account No.



Your email address (mandatory)

Once registered, your reimbursements for health care services will be deposited into this bank account. A notification email will be sent once your claims have been processed, and the explanation of benefits will be posted online rather than mailed. You must be registered on the secure site to consult your explanation of benefits. To register, go to desjardinslifeinsurance.com/planmember.

Desjardins Insurance is not responsible for the accuracy of the banking information you enter and for verifying that the due amounts are deposited into your account.

SECTION G. 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 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 H. 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 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. 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 the insured: **Date:**

Telephone Nos: Home: Office: Extension:

SECTION I. DENTAL TREATMENT DUE TO AN ACCIDENT

TO BE COMPLETED BY THE INSURED

Date of the accident: YYYY MM DD Location of the accident:

How did the accident occur?

If the claim is the result of a work injury or a motor vehicule accident, please note that the claim must first be submitted to your provincial automobile insurance (if applicable in your province) or occupational health and safety plan before being forwarded to your insurer.

TO BE COMPLETED BY THE DENTIST

Is it an accidental injury to a healthy and natural tooth? ☐ Yes ☐ No

Diagnosis and clinical description prior to the accident:

Preoperative X-rays are required for the study of dental treatment due to an accident. They will be returned to the attending dentist as soon as possible.

SECTION J. CLAIM FOR A CROWN, VENEER, INLAY/ONLAY, FIXED BRIDGE OR DENTURE

- **For crown, veneer or inlay/onlay:** Please submit pre-treatment x-rays. If replacement, please indicate the age of the existing appliance.
- **For fixed bridge:** Please submit pre-treatment x-rays with clear views of both sides of the arch(s). If replacement, please indicate the age and type of the existing prosthesis. If initial, please indicate the extraction date of the missing teeth.
- **For denture:** If replacement, please indicate the age and type of the existing prosthesis. If initial, please indicate the extraction date of the missing teeth.

Please include a copy of the commercial lab bill with your claim.

Sign section H and send to: Desjardins Insurance, C. P. 3950, Lévis (Québec) G6V 8C6

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