Desjardins Insurance
Life • Health • Retirement

C. P. 3950
Lévis (Québec) G6V 8C6
1-800-263-1810

CLAIM FOR HEALTH CARE BENEFITS

Would you like to submit your claim online?
Go to desjardinslifeinsurance.com/planmember

✓ **Online and mobile services**
✓ **Direct deposit**

SECTION A. IDENTIFICATION (MANDATORY) – This information can be found on your insurance certificate or payment card.

Policy or group or contract No.	**Certificate No.**	Name of group or policyholder or employer

Member's last name and first name

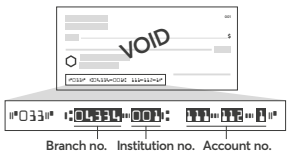
Date of birth YYYY MM DD

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

SECTION B. 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 Financial Security Life Assurance Company (DFS), hereinafter 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 C. COORDINATION OF BENEFITS

If you are covered by more than one insurance plan, the coordination of benefits may entitle you to a reimbursement of up to 100% of your eligible expenses.

HOW TO SUBMIT A CLAIM WHEN THERE ARE TWO INSURANCE PLANS:

1. The person who has the other insurance plan must submit a claim to their own insurer first and then provide Desjardins Insurance with detailed information about the benefits paid (information found on the explanation of benefits), as well as copies of any receipts.
2. Claims for dependent children must first be submitted under the plan of the parent whose birthday (month and day) comes first in the calendar year.

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 benefits: ☐ Drugs ☐ Dental care ☐ Supplementary health care ☐ Vision care ☐ Travel

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

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

1. 3.
2. 4.

SECTION D. HEALTH SPENDING ACCOUNT – If you have this benefit, check the option you would like.

I confirm that I am eligible for a reimbursement of the indicated expenses under my Health Spending Account.

I recognize that I am responsible for paying any taxes that may result from the reimbursement of these expenses and that, for tax or administrative purposes, my plan administrator may have access to a statement of expenses for which I claimed a reimbursement under my Health Spending Account.

If you don't choose an option, the portion of expenses that isn't covered by your plan will be automatically submitted to the Health Spending Account for reimbursement.

☐ I do not wish to use my Health Spending Account.

☐ **Ineligible expenses** – I wish to use my Health Spending Account to cover the expenses that are not reimbursed under my group insurance plan.

☐ **Spouse's family coverage** – I wish to use my Health Spending Account for myself and my dependent children to cover the expenses that are not reimbursed under my group insurance plan. I will not submit a claim to my spouse's insurer (coordination of benefits).

- **If your claim is for a dependent, accident-related expenses, out-of-province expenses or an assignment of benefits, please complete the appropriate section on the back of the form.**
- **Please sign section I and send the form and original receipt to: Desjardins Insurance, C. P. 3950, Lévis (Québec) G6V 8C6**

SECTION E. INFORMATION ABOUT DEPENDENTS – For the period in which expenses were incurred.

I confirm that the persons designated below meet the definition of spouse and dependent child as specified in the contract under which this claim has been submitted.

CHILDREN AGED 18 AND OVER OR 21 AND OVER (depending on the contract)
If your child has a functional impairment, please provide us with a medical certificate confirming your child's disability.

1 Last name and first name | Relation ☐ Spouse ☐ Child | Date of birth YYYY MM DD

☐ Has a functional impairment ☐ Full-time student – Name of educational institution attended:

Period: From: YYYY MM DD To: YYYY MM DD

2 Last name and first name | Relation ☐ Spouse ☐ Child | Date of birth YYYY MM DD

☐ Has a functional impairment ☐ Full-time student – Name of educational institution attended:

Period: From: YYYY MM DD To: YYYY MM DD

3 Last name and first name | Relation ☐ Spouse ☐ Child | Date of birth YYYY MM DD

☐ Has a functional impairment ☐ Full-time student – Name of educational institution attended:

Period: From: YYYY MM DD To: YYYY MM DD

In the case of a change of spouse, please indicate:

☐ Start date of cohabitation: YYYY MM DD OR ☐ Date of marriage: YYYY MM DD

Child born of this union? ☐ No ☐ Yes → Date of birth: YYYY MM DD

SECTION F. INFORMATION ABOUT AN ACCIDENT-RELATED CLAIM

Last name and first name of injured person | Date of accident YYYY MM DD

Is the claim the result of: ☐ a work injury? ☐ a motor vehicle accident?

IMPORTANT – Please note that the claim must first be submitted under your provincial workers' compensation plan or automobile insurance plan (if applicable in your province) before being submitted to your group insurance plan.

SECTION G. OUT-OF-PROVINCE EXPENSES

This is not a travel insurance form. Visit desjardinslifeinsurance.com/travel-claim to find the correct form.

Please include the original receipt itemizing all of your out-of-province expenses.

Length of trip: From YYYY MM DD To YYYY MM DD Destination _____ Amount claimed $ _____

Reason for trip: ☐ Pleasure ☐ Business ☐ Receive care (please ensure that this type of trip is covered by your contract)

SECTION H. ASSIGNMENT OF BENEFITS – Fill out this section if benefits are to be assigned to the health care provider.

Identification of the health care provider (name of the company or first and last names of the specialist) | Telephone No.

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

I understand that the expenses being claimed may not be covered by the insurer or may exceed the maximum benefit payable. I also understand that I am responsible for paying these expenses. I hereby assign benefits payable to the health care provider designated above and authorize the insurer to pay this provider directly.

Signature of the member: _____ **Date:** _____

Health care provider's signature: _____ **Date:** _____

SECTION I. 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 member: **Date:**

Telephone Nos: Home: Office: Extension:

SECTION J. 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.

Please send to: Desjardins Insurance, C. P. 3950, Lévis (Québec) G6V 8C6

PRINT NEW REQUEST