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.

Desjardins Insurance refers to Desjardins Financial Security Life Assurance Company.

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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	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	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. Personal information management

Desjardins Insurance handles the personal information it has on you in a confidential manner. Desjardins Insurance keeps this information on file so that you can benefit from the financial services (insurance, annuities, credit, etc.) it offers. This information is consulted solely by Desjardins Insurance employees who need to do so in the course of their work.

You have the right to consult your file. You may also have information corrected if you demonstrate that it is inaccurate, incomplete, ambiguous or not useful. To do so, you must send a written request to the following address: Privacy Officer, Desjardins Insurance, 200, rue des Commandeurs, Lévis, Québec, G6V 6R2.

Desjardins Insurance can send promotional information or offer new products to individuals whose names appear on its client list. Desjardins Insurance may also give its client list to another component of the Desjardins Group for the same purposes. If you do not want to receive such offers, you may have your name removed from the list by sending a written request to the Privacy Officer at Desjardins Insurance.

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 transferred to another country and be subject to the laws of that country. For information about Desjardins Insurance's policies and practices regarding the transfer of personal information outside of Canada, visit the Desjardins Insurance website at www.desjardinslifeinsurance.com or write to the Desjardins Insurance Privacy Officer at the address indicated above. The Privacy Officer can also answer any questions about the transfer of personal information to service providers located outside of Canada.

F. Authorization to collect and communicate personal information

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

For the sole purpose of determining insurability, managing files and processing claims, I authorize Desjardins Insurance or its reinsurers: (a) to collect from any individual, legal entity or public or parapublic organization only the personal information they have about me that is needed to process my file. This information may be collected from third parties, including any health care professional or establishment, MIB, LLC, insurance and reinsurance companies, personal information brokers, investigation firms, the contract holder, my employer or my former employers; (b) to disclose to those individuals, legal entities or public or parapublic organizations only the personal information they have about me that is needed to manage my file; (c) to request, if applicable, an investigation report about me and to use the personal information contained in other files it may have that are now closed; (d) to disclose to my personal physician any medical information about me that was obtained during the evaluation of my file; (e) to disclose to other insurers or reinsurers any information about me that is relevant to determining my eligibility for insurance or for benefits; (f) to provide a brief report on my personal information, including my health information, to MIB, LLC. This authorization also applies to the collection, use and communication of personal information regarding my dependents, insofar as applicable to my claim.
I agree that a copy of this authorization is as valid as the original and will continue to have effect throughout the duration of my claim.

X ______________________________ ______________
Signature of insured person or authorized representative Date (YYYY-MM-DD)

G. Policyholder's statement

To be completed by the policyholder if other than the insured person

I hereby certify that the above information is true and complete.

X ______________________________ ______________
Policyholder's signature Date (YYYY-MM-DD)

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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	Postal code

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

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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	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.