Desjardins Financial Security®

P.O. Box 4358, STN A
Toronto ON M5W 3M3

FINANCIAL SERVICES INCLUDING INSURANCE, ANNUITIES, CREDIT AND RELATED SERVICES

CLAIM FOR HEALTH CARE BENEFITS

TO EXPEDITE PROCESSING OF YOUR CLAIM, PLEASE ANSWER ALL QUESTIONS.
(Missing or inaccurate information may result in handling delays, and the form may be returned to you for correction.)

A

Policy or group or contract No.

Certificate No.

Member's last name and first name

Sex ☐ M ☐ F

Date of birth YYYY MM DD

Number, street, apartment

City, province

Postal code

Name of group or policyholder or employer

IF GROUP IS SELF-ADMINISTERED the administrator must complete this section before the member fills out the form

In force: Individual (YYYY MM DD)

Family (YYYY MM DD)

Other, specify (YYYY MM DD)

Terminated (YYYY MM DD)

Administrator's signature

Date

B

Is the claim the result of:

• a work injury? ☐ Yes ☐ No **• a motor vehicle accident?** ☐ Yes ☐ No

If yes:
- 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 plan.
- Name of injured person:

Date of accident: YYYY MM DD

C

COORDINATION OF BENEFITS - This section MUST BE COMPLETED if claiming for a spouse or child.
The coordination of benefits may entitle you to a reimbursement of up to 100% of your expenses.

HOW TO SUBMIT A CLAIM WHEN THERE ARE TWO INSURERS

1. Your spouse must first submit his or her claim to his or her own insurer and provide Desjardins Financial Security Life Assurance Company with the explanation of benefits paid by their plan including copies of the 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.

Is your spouse insured under another insurance contract that provides benefits for:

• drugs: ☐ Yes ☐ No **• paramedical services:** ☐ Yes ☐ No **• vision care:** ☐ Yes ☐ No

If yes, is the coverage: ☐ individual ☐ family

Effective date YYYY MM DD

Termination date YYYY MM DD

Full name of spouse

Date of birth YYYY MM DD

Name of insurer:

Policy no.:

Certificate no.:

D

PATIENT INFORMATION for the period in which expenses were incurred (use one line per patient).
I confirm that the persons designated below fit the definition of spouse and dependent child as specified in the contract under which this claim has been submitted.

CHILDREN AGED 18 OR 21 OR OLDER (the specific age depends on the plan provisions)

Last name	First name	Participant	Spouse	Child	Sex	Date of birth	Full-time student	Name of educational institution attended
		☐	☐	☐	☐ M ☐ F	YYYY MM DD	☐ Yes ☐ No From (YYYY MM DD) To	
		☐	☐	☐	☐ M ☐ F	YYYY MM DD	☐ Yes ☐ No From (YYYY MM DD) To	
		☐	☐	☐	☐ M ☐ F	YYYY MM DD	☐ Yes ☐ No From (YYYY MM DD) To	
		☐	☐	☐	☐ M ☐ F	YYYY MM DD	☐ Yes ☐ No From (YYYY MM DD) To	

E

DIRECT DEPOSIT AND ELECTRONIC NOTICE SERVICE

- This service enables you to receive your health claim payments by direct deposit and to be informed by e-mail when your claim has been processed.
- **To enroll in this service**, please attach a specimen cheque marked "VOID" and provide your E-mail address:
- For more details on this service or to make changes to it, please visit our Web site at www.dfsgroupinsurance.com.

F

HEALTH SPENDING ACCOUNT - Complete this section if you have this coverage.

1. Should the portion of expenses not covered under your contract be applied against your health spending account? ☐ Yes ☐ No
2. If you or your dependent children are covered under your spouse's insurance plan, would you like the portion of expenses not paid under the basic plan to be automatically processed through the health spending account instead of submitting them for coordination to your spouse's insurer? ☐ Yes ☐ No
3. Would you like the expenses for items requiring a medical recommendation to be paid automatically into the health spending account, if this recommendation is not appended to your claim? ☐ Yes ☐ No

IMPORTANT INFORMATION

- **Send original receipts only (copies will not be accepted). Please keep copies for your records, the originals will not be returned. The explanation of benefits you will receive from us, along with copies of your receipts, are acceptable proof of expense for income tax purposes and coordination of benefits with other carriers.**
- **Claims MUST BE submitted no later than one year after expenses are incurred.**

G DRUG EXPENSES

- Attach your prescription drug receipts to this form.
- All receipts must contain the drug identification number (DIN) and the name of the drug.

H MEDICAL/PARAMEDICAL EXPENSES (e.g.: chiropractor, massage therapist, physiotherapist)

If a medical recommendation is required under the terms of your policy, please include it.

Please attach an itemized statement or a receipt stating:

- patient's name
- practitioner's name
- practitioner's licence or registration number
- type of practitioner
- length of visit
- date(s) of visit(s)
- charge for each treatment
- date at which the patient reached the maximum payable by province's health plan (if applicable)

If for psychotherapy, please indicate the type: ☐ individual ☐ family ☐ group ☐ marriage

I EQUIPMENT AND APPLIANCE EXPENSES

If required under the terms of your policy (usually required under all policies, but please consult your booklet if you are unsure) provide the attending physician's written recommendation for the equipment or appliance prescribed, including the diagnosis, and a copy of the provincial-plan payment summary, if applicable.

Indicate the period of time the equipment will be required: from: _____ to: _____

J VISION CARE EXPENSES

Please attach an itemized receipt stating:

- patient's name
- cost of frames
- cost of lenses
- cost of contact lenses
- cost of tinting
- cost of eye exam
- date of eye exam
- date dispensed

Are you claiming expenses incurred to replace a pair of glasses? ☐ Yes ☐ No

Was a new eye exam required to replace the glasses? ☐ Yes ☐ No If yes, enclose a true copy of the old and new prescriptions (if required by your contract).

K PERSONAL INFORMATION MANAGEMENT

Desjardins Financial Security Life Assurance Company (DFS) handles the personal information it has on you in a confidential manner. DFS keeps this information on file so that you may benefit from group insurance services offered by the Company. This information is consulted solely by DFS 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 Financial Security Life Assurance Company, 200, rue des Commandeurs, Lévis, Québec, G6V 6R2. DFS may use the client list to offer its clients an insurance product following the termination of their group insurance. If you do not wish to receive these offers, you may have your name removed from the list. To do so, you must send a written request to the Privacy Officer at DFS.

L DECLARATION AND AUTHORIZATION FOR THE COLLECTION 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 Financial Security Life Assurance Company, 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.

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: (Area code + Number) _____ Office: (Area code + Number) _____ Extension: _____

Print