Desjardins Insurance
LIFE • HEALTH • RETIREMENT

C. P. 3950
Lévis (Québec) G6V 8C6

GROUP INSURANCE - HEALTH CLAIMS

CLAIM FOR HEALTH CARE BENEFITS

Claims processed within 2 business days?
✓ Online and mobile services ✓ Direct deposit
Visit desjardinslifeinsurance.com/planmember to find out more.

IN ORDER FOR US TO PROCESS YOUR CLAIM, PLEASE ANSWER ALL QUESTIONS THAT APPLY TO YOUR SITUATION AND SIGN SECTION H.

A - IDENTIFICATION - MANDATORY SECTION

This information can be found on your insurance certificate.

Policy or group or contract no.	Name of group or policyholder or emloyer
Q178	**GROUP HEALTH AND HOSPITALIZATION INSURANCE PLAN FOR FOREIGN UNIVERSITY STUDENTS**

Last name and first name of member	Sex ☐ M ☐ F	Date of birth YYYY MM DD	Certificate no.

Address - No., street, apartment	City	Province	Postal code

B - ASSIGNMENT OF BENEFITS

Do you wish the refund to be paid to the practitioner? ☐ Yes ☐ No

C - INFORMATION ABOUT EXPENSES INCURRED IN CANADA

If care has been provided in Canada and a claim for medical fees is being submitted, the attending physician must complete this section.

Diagnosis: (PLEASE PRINT) _____

Date YYYY MM DD	Description of services	Diagnostic code	Procedure code	Fees
				$
				$
				$
				$

Last name and first name of attending physician (PLEASE PRINT)	License no.

Address - No., street, suite	City	Province	Postal code

Telephone no.: ( ) -

Signature of attending physician: **Date:**

D - INFORMATION ABOUT EXPENSES OUTSIDE CANADA

If expenses have been incurred during a trip outside Canada, please complete this section.

Date of departure: YYYY MM DD	Anticipated date of return to Canada: YYYY MM DD	Actual date of return to Canada: YYYY MM DD

SERVICES RECEIVED – Provide reason for medical or hospital services provided:

Describe services received (e.g.: examination, X-rays, surgery, etc.). If you need more space, use a separate sheet.

City and country where services were rendered:

If services were required because of an accident, please specify: Date of accident: YYYY MM DD	Type of accident: ☐ Automobile ☐ Work ☐ Other (specify): _____

Amount claimed: $ _____ ☐ Canadian currency ☐ Other currency: _____	Has the bill been paid? ☐ Yes ☐ In full ☐ In part → $ _____ Amount ☐ No

PLEASE COMPLETE THE BACK OF THE FORM.

IMPORTANT INFORMATION

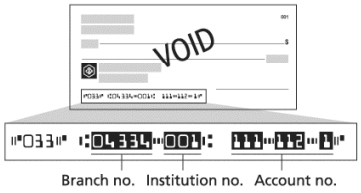
- **Attach your original receipts to this form and keep copies for your files. The original copies will not be returned. Your explanation of benefits and the copies of your receipts are sufficient for income tax and coordination of benefit purposes.**
- **Claims MUST BE submitted no later than one year after expenses are incurred.**

E - 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 healthcare 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.

F - INFORMATION ABOUT THE CLAIM

Is the claim the result of:

- **a work injury?** ☐ **Yes** ☐ **No**
- **a motor vehicle accident?** ☐ **Yes** ☐ **No**
- **other?** ☐ **Yes** ☐ **No** **Specify:** _____

If so, has a claim been submitted to a government agency such as the Commission des normes, de l'équité, de la santé et de la sécurité du travail (CNESST) or Société de l'assurance automobile du Québec (SAAQ), etc.? ☐ Yes ☐ No

G - 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 may benefit from group insurance services offered by the Company. This information is consulted solely by Desjardins Insurance employees who need to do so in the course of their work. Desjardins Insurance may compile anonymized personal information for statistical and informational purposes. Desjardins Insurance may also communicate with plan members to provide them with optimal health management. 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 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 Desjardins Insurance.

H - 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 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.

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:

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

PRINT NEW REQUEST