

# CONFIRMATION OF A DEPENDENT CHILD'S FUNCTIONAL IMPAIRMENT

## SECTION A. IDENTIFICATION

Member's last name and first name

Policy or group or contract number

Certificate number

Dependent child's last name and first name

Date of birth of dependent child  
YYY MM DD

Does the child live with you?

Yes

No

If no, where does the child live?

Name of the person the child lives with

Number, street, apartment

City

Province

Postal code

## SECTION B. GENERAL INFORMATION – To be completed by the member

1. Please describe the child's functional impairment:

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2. Start date of functional impairment:

YYY MM DD

3. Please describe the child's work experience:

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Please describe the limitations that prevent the child from being gainfully employed:

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4. Is the child eligible for government assistance because of his/her functional impairment?  Yes  No

If an application related to a functional impairment has been made, please indicate the decision (approval or denial) and provide us with a copy of all documents submitted to and received from the government: \_\_\_\_\_

## SECTION C. 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 at the back of this form. I authorize Desjardins Financial Security Life Assurance Company, hereinafter 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: \_\_\_\_\_

**PLEASE HAVE THE CHILD'S ATTENDING PHYSICIAN COMPLETE THE BACK OF THIS FORM.**

**SECTION D. MEDICAL INFORMATION** – To be completed by the attending physician.

1. Clinical diagnosis:  Permanent  Temporary

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2. Please describe the nature and degree of the mental or physical functional impairment:

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3. Date of diagnosis:

YYYY MM DD

4. To what degree does the physical or mental functional impairment prevent the child from performing his/her normal everyday activities?

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5. What type of work is the child capable of doing?

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6. Indicate the periods during which the child was not able to work or attend school full time because of his/her functional impairment:

First period: From YYYY MM DD \_\_\_\_\_ To YYYY MM DD \_\_\_\_\_ Second period: From YYYY MM DD \_\_\_\_\_ To YYYY MM DD \_\_\_\_\_  
Third period: From \_\_\_\_\_ To \_\_\_\_\_ Fourth period: From \_\_\_\_\_ To \_\_\_\_\_

7. What is your prognosis with regard to the child's functional impairment?

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**SECTION E. IDENTIFICATION OF THE PHYSICIAN** – To be completed by the attending physician.

Last name and first name of the physician

License number

Number, street, suite

City

Province

Postal code

Telephone number

Fax number

Email address

I hereby certify that the above answers are full and true.

**Signature of the physician:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**SECTION F. 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](http://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.