

Section A. General information – To be completed by the member.

Last name and first name of member		Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth YYYY MM DD		Policy or group or contract No.
Address	No., street, apartment				Certificate No.
	City	Province	Postal code		
Name of the person for whom expenses were incurred			Relationship to member		Date of birth YYYY MM DD
Name of group or policyholder or employer		Signature of administrator (if required)		Date YYYY MM DD	
1. Type of event (check the corresponding event(s))		<input type="checkbox"/> Hospitalization <input type="checkbox"/> Surgery		Date of event YYYY MM DD	
2. Describe the circumstances that led to the hospitalization, surgery or accident:					

3. Are the claimed benefits covered under another insurance contract? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If yes: Name of insurer: _____			Contract No.: _____		
4. Was Assistel contacted before services were received? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If yes, file No.: _____					

IMPORTANT: IF YOUR RETURN TO WORK IS ANTICIPATED, PLEASE ADVISE THE INSURER ON THE RETURN DATE.

Section B. 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 Financial Security Life Assurance Company, hereinafter 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.

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. 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. 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 member _____ Date _____

Telephone Nos.: Home: _____ Office: _____ Extension: _____

Section D. Convalescence period – To be completed by the attending physician who prescribed the convalescence.

- Diagnosis: _____
- Treatment or type of surgery: _____
YYYY MM DD YYYY MM DD
- Hospitalization: Admission date: _____ Discharge date: _____
Name of hospital: _____
- Check the loss of autonomy criteria justifying a period of convalescence:

<input type="checkbox"/> Eating	- The insured person needs assistance in preparing meals or feeding himself.
<input type="checkbox"/> Moving	- The insured person needs assistance in getting out of a bed or a chair, lying down or sitting.
<input type="checkbox"/> Dressing	- The insured person needs assistance in putting on or taking off his clothes and his orthopedic prosthesis.
<input type="checkbox"/> Taking care of basic hygiene needs	- The insured person needs assistance in washing, getting in or out of the bathtub or shower or using the toilet.
- Period of prescribed convalescence: period during which the insured person must necessarily present one or more loss of autonomy criteria listed above:
From _____ To _____ Number of days: _____
- Did you recommend home nursing care? Yes No If yes, for which type of services? _____
YYYY MM DD
- Did the insured person previously consult you or another professional for the condition requiring hospitalization or surgery before _____? Yes No
If yes, please provide the following information:

Name of attending physician	Date of visits YYYY MM DD	Diagnosis	Treatments
_____	YYYY MM DD	_____	_____
_____	YYYY MM DD	_____	_____
_____	YYYY MM DD	_____	_____
- Was the convalescence prescribed following a delivery? Yes No
If yes, was the insured person hospitalized at your recommendation for more than seven (7) days **after** delivery due to complications?
 Yes No If yes, please indicate the:
 - Number of days in hospital (after delivery): _____ days
 - Details of complications: _____

Name and address of the attending physician (PLEASE PRINT)

_____ Licence No.: _____

_____ Telephone No.: _____

Signature of attending physician: _____ Date: _____

For all benefits claimed: 1. You must submit the original receipt which includes all details of services rendered.
2. When the space available is not sufficient, you may attach a separate sheet which you must date and sign.

Section E. Domestic assistance services – To be completed by the insured person or by the member.

Date of services			Details of services	Number of days	Fees per day
YYYY	MM	DD			
_____	_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	_____	\$ _____

Name of provider: _____

Address: _____

Telephone No.: _____

Relationship to member: Friend Family member Other, please specify: _____

Section F. Home nursing care – To be completed by the insured person or by the member.

What services were provided?	Date of services			Hourly rate	Number of hours	Amount
	YYYY	MM	DD			
_____	_____	_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	_____	_____	\$ _____

Name of the nurse: _____

Address: _____

Licence No.: _____ Telephone No.: _____

Relationship to member: Friend Family member Other, please specify: _____

Section G. Stay in a convalescent facility – To be completed by the insured person, by the member or by the convalescent facility.

Name and address of the convalescent facility

Duration of stay: _____
 From: _____ To: _____ Amount: \$ _____

Section H. Custodial services – To be completed by the insured person or by the member.

Date of services			Name of child	Date of birth			Amount claimed	Amount normally paid for child care
YYYY	MM	DD		YYYY	MM	DD		
_____	_____	_____	_____	_____	_____	_____	\$ _____	\$ _____
_____	_____	_____	_____	_____	_____	_____	\$ _____	\$ _____
_____	_____	_____	_____	_____	_____	_____	\$ _____	\$ _____

Name of baby-sitter: _____

Address: _____

Telephone No.: _____

Relationship to member: Friend Family member Other, please specify: _____

Section I. Transportation expenses – To be completed by the insured person or by the member and signed by each physician or health care professional consulted.

Only eligible following surgery or hospitalization.

Dates	Round-trip transportation used	Care provided	Name, address and licence No. of physician or health care professional
_____	\$ _____ Taxi	_____	Signature of physician or health care professional _____ _____
	_____ km \$ _____ Private car Parking		
_____	\$ _____ Public transit	_____	Signature of physician or health care professional _____ _____
	\$ _____ Taxi		
	_____ km \$ _____ Private car Parking		
_____	\$ _____ Public transit	_____	Signature of physician or health care professional _____ _____
	\$ _____ Taxi		
	_____ km \$ _____ Private car Parking		
_____	\$ _____ Public transit	_____	