Desjardins Insurance
Life • Health • Retirement

C. P. 3950
Lévis (Québec) G6V 8C6
desjardins.com/planmember
1-800-263-1810

HOME CARE CLAIM

Section A. General information (to be completed by the plan member)

Last name and first name of plan member	Date of birth YYYY MM DD	Group No.

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

Name of the person for whom expenses were incurred	Relationship to plan member	Date of birth YYYY MM DD

Name of group, policyholder or employer	**Signature of administrator if required**	**Date** YYYY MM DD

1. Type of event (check the corresponding events) ☐ Hospitalization ☐ Surgery — Date of event YYYY MM DD

2. Describe the circumstances that led to the hospitalization or surgery _____

3. Are the claimed benefits covered by another insurance contract? ☐ Yes ☐ No

If yes: Name of insurer: _____ Contract No.: _____

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

Section B. Convalescence period (to be completed by the attending physician who prescribed the convalescence period)

Physician's last and first name (PLEASE PRINT)	License No.	Specialty

No., street, suite	City	Province	Postal code

Telephone No.	Fax No.

Signature of physician _____ **Date** _____

1. Diagnosis: _____

2. Treatment or type of surgery _____

3. Hospitalization: Admission date (YYYY MM DD) _____ Discharge date (YYYY MM DD) _____

Name of hospital: _____

4. Check the criteria for loss of autonomy that justify the convalescence period:

☐ Eating	- The insured person needs assistance preparing meals or feeding themselves.
☐ Moving	- The insured person needs assistance getting out of bed or a chair, lying down or sitting.
☐ Dressing	- The insured person needs assistance putting on or taking off their clothes and orthopedic prostheses.
☐ Taking care of basic hygiene needs	- The insured person needs assistance washing, getting in or out of the bath or shower, or using the toilet.

5. Prescribed convalescence period: period during which the insured person meets one or more of the criteria for loss of autonomy listed above:

From (YYYY MM DD) _____ To (YYYY MM DD) _____ Number of days: _____

6. Was the convalescence period prescribed following delivery? ☐ Yes ☐ No

If yes, was the insured person hospitalized for more than seven (7) days **after** delivery due to complications?

☐ Yes ☐ No If yes, please indicate the: a) Number of days in hospital (after delivery): _____ days

b) Details of complications : _____

For all claimed expenses:

1. You must submit the original receipt detailing the services received.
2. If the space provided is insufficient, you may attach a separate sheet which you must date and sign.

Section C. Home care services (to be completed by the insured person or plan member)

Date of each service YYYY-MM-DD	Details of services	Number of days	Fees per day
			$
			$
			$
			$
			$
			$

Name of provider

Relationship to plan member
☐ Friend ☐ Family member ☐ Other, specify ______

No., street, suite	City	Province	Postal code

Telephone No.

Section D. Childcare services (to be completed by the insured person or plan member)

Date of services YYYY-MM-DD	Name of each child	Date of birth YYYY-MM-DD	Amount claimed	Amount normally paid for child care
______	1. ______ 2. ______ 3. ______ 4. ______	1. ______ 2. ______ 3. ______ 4. ______	______ $	______ $
______	1. ______ 2. ______ 3. ______ 4. ______	1. ______ 2. ______ 3. ______ 4. ______	______ $	______ $
______	1. ______ 2. ______ 3. ______ 4. ______	1. ______ 2. ______ 3. ______ 4. ______	______ $	______ $
______	1. ______ 2. ______ 3. ______ 4. ______	1. ______ 2. ______ 3. ______ 4. ______	______ $	______ $
______	1. ______ 2. ______ 3. ______ 4. ______	1. ______ 2. ______ 3. ______ 4. ______	______ $	______ $

Name of baby-sitter

Relationship to plan member
☐ Friend ☐ Family member ☐ Other, specify ______

No., street	City	Province	Postal code

Telephone No.

Section E. Transportation expenses (to be completed by the insured person or plan member and signed by each consulted physician or health care professional)

Only eligible following surgery or hospitalization.

Date of each service YYYY-MM-DD	Transportation used (round trip)	Care provided	Signature of physician or healthcare professionnal	Contact information of physician or healthcare professional
	Taxi _____ $ Private car _____ km Parking _____ $ Public transit _____ $			Name _____ Address _____ Licence No. _____
	Taxi _____ $ Private car _____ km Parking _____ $ Public transit _____ $			Name _____ Address _____ Licence No. _____
	Taxi _____ $ Private car _____ km Parking _____ $ Public transit _____ $			Name _____ Address _____ Licence No. _____
	Taxi _____ $ Private car _____ km Parking _____ $ Public transit _____ $			Name _____ Address _____ Licence No. _____

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 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 documentation, 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 G. 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 plan member **Date**

Telephone Nos: Home: Office: Extension:

Keep a copy for your records and send to:
Desjardins Insurance, C. P. 3950, Lévis (Québec) G6V 8C6

PRINT **NEW REQUEST**