

CLAIM FOR DENTAL CARE EXPENSES

SECTION A. DENTIST INFORMATION

| | | |
|------------------------------|---------------|------------------|
| Last name and first name | Member number | Telephone number |
| Address – No., street, suite | City | Province |
| | | Postal code |

SECTION B. CLAIM INFORMATION

IMPORTANT: If the claim is for dental treatment due to an accident, a crown, veneer application, inlay or denture, please refer to sections J and K.
If the treatment requires more than one session, the date of treatment must be the date on which the treatment terminates or the insertion date.

| Last name and first name of the patient | | | | | | | Date of birth YYYY MM DD | | Relationship to the member <input type="checkbox"/> Spouse <input type="checkbox"/> Daughter <input type="checkbox"/> Son | | |
|---|-----------|----------------|---------------|---------------------|----------------|--------------|---|--|--|--|--|
| Treatment date YY MM DD | Tooth No. | Procedure code | Tooth surface | Laboratory expenses | Dentist's fees | Total charge | Diagnosis – This section is reserved for the dentist: THIS IS AN ACCURATE STATEMENT OF SERVICES PERFORMED AND FEES CHARGED. | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| Total fee claimed: | | | | | | | Signature of dentist: | | Date: | | |

SECTION C. ASSIGNMENT OF BENEFITS

I hereby assign benefits payable from this claim to the above named dentist and authorize Desjardins Financial Security Life Assurance Company, hereinafter Desjardins Insurance, to pay the dentist directly.

Signature of member: _____ Date: _____

SECTION D. MEMBER INFORMATION – To be completed by the member.

| | | | | | | |
|---|--|---------------------------------|------|--|-----------------------------|--|
| Name of group or policyholder or employer | | Policy or group or contract No. | | Certificate No. | | |
| Member's last name and first name | | | | Sex <input type="checkbox"/> M <input type="checkbox"/> F | Date of birth YYYY MM DD | |
| Address – No., street, apartment | | | City | Province | Postal code | |

Complete only if you are claiming expenses incurred for your dependent children aged 18 and over or 21 and over (depending on the contract). Remember to include the information for the period in which the expenses were incurred for your child. If your child has a functional impairment, please provide us with a medical certificate confirming your child's disability.

Has a functional impairment
 Full-time student – Name of educational institution attended: _____ Period: From _____ To _____

SECTION E. COORDINATION OF BENEFITS – To be completed by the member.

| | | | | | | |
|---|--|--|------------------------|--|---|--|
| Last name and first name of person who has the other insurance plan | | | | Sex <input type="checkbox"/> M <input type="checkbox"/> F | Date of birth YYYY MM DD | |
| Name of insurer <input type="checkbox"/> Other <input type="checkbox"/> Desjardins Insurance – Contract No.: _____ | | | Certificate No.: _____ | | Period of coverage From _____ To _____ | |
| Type of dental coverage: <input type="checkbox"/> Individual <input type="checkbox"/> Couple <input type="checkbox"/> Single-parent <input type="checkbox"/> Family | | | | | | |
| Last name and first name of the dependents covered under this other insurance plan | | | | | | |

SECTION F. HEALTH SPENDING ACCOUNT – If you have this benefit, check the option you would like.

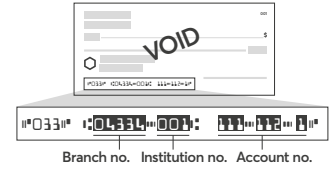
I confirm that I am eligible for a reimbursement of the indicated expenses under my Health Spending Account. I recognize that I am responsible for paying any taxes that may result from the reimbursement of these expenses and that, for tax or administrative purposes, my plan administrator may have access to a statement of expenses for which I claimed a reimbursement under my Health Spending Account.

If you don't choose an option, the portion of expenses that isn't covered by your plan will be automatically submitted to the Health Spending Account for reimbursement.

I do not wish to use my Health Spending Account.
 Ineligible expenses – I wish to use my Health Spending Account to cover the expenses that are not reimbursed under my group insurance plan.
 Spouse's family coverage – I wish to use my Health Spending Account for myself and my dependent children to cover the expenses that are not reimbursed under my group insurance plan. I will not submit a claim to my spouse's insurer (coordination of benefits).

SECTION G. 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 health care 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 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.

SECTION H. 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 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 I. DECLARATION AND AUTHORIZATION FOR THE COLLECTION, USE AND COMMUNICATION OF PERSONAL INFORMATION

I understand that I am responsible for the total cost of the treatment. 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 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:

Telephone Nos:

Home:

Office:

Extension:

SECTION J. DENTAL TREATMENT DUE TO AN ACCIDENT

► **To be completed by the member**

YYYY MM DD

Date of the accident: _____ Location of the accident: _____

How did the accident occur? _____

If the claim is the result of a work injury or a motor vehicle accident, please note that the claim must first be submitted to your provincial automobile insurance (if applicable in your province) or occupational health and safety plan before being forwarded to your insurer.

► **To be completed by the dentist**

Is it an accidental injury to a healthy and natural tooth? Yes No

Diagnosis and clinical description prior to the accident: _____

Preoperative X-rays are required for the study of dental treatment due to an accident. They will be returned to the attending dentist as soon as possible.

SECTION K. CLAIM FOR A CROWN, VENEER, INLAY/ONLAY, FIXED BRIDGE OR DENTURE

- **For crown, veneer or inlay/onlay:** Please submit pre-treatment x-rays. If replacement, please indicate the age of the existing appliance.
- **For fixed bridge:** Please submit pre-treatment x-rays with clear views of both sides of the arch(s). If replacement, please indicate the age and type of the existing prosthesis. If initial, please indicate the extraction date of the missing teeth.
- **For denture:** If replacement, please indicate the age and type of the existing prosthesis. If initial, please indicate the extraction date of the missing teeth.

Please include a copy of the commercial lab bill with your claim.

Sign section I and send to: Desjardins Insurance, C. P. 3950, Lévis (Québec) G6V 8C6