Desjardins Financial Security®

C. P. 3950
Lévis (Québec) G6V 8C6

GROUP INSURANCE - HEALTH CLAIMS

CLAIM FOR HEALTH CARE BENEFITS

TO EXPEDITE PROCESSING OF YOUR CLAIM, PLEASE ANSWER ALL QUESTIONS.

A - IDENTIFICATION

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

Member's last name and first name	Sex	Date of birth	Certificate no.
	☐ M ☐ F	YYYY MM DD	

Number, 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 CARE PROVIDED 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	Description of services	Diagnostic code	Procedure code	Fees
YYYY MM DD				$
YYYY MM DD				$
YYYY MM DD				$
YYYY MM DD				$

Name and address of attending physician (PLEASE PRINT)

______

______

______

Licence No.: ______

Telephone No.: (   ) ______

Signature of attending physician ______

Date ______

D - INFORMATION ABOUT CARE INCURRED 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 – Give reason for medical or hospital services provided.

______

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

______

Town 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 ☐ (Specify)

Has the bill been paid?

☐ Yes ☐ In full ☐ In part ▶ Amount $ ______

☐ No

PLEASE COMPLETE THE BACK OF THE FORM

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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.**

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 de la santé et de la sécurité du travail (CSST) or Société de l'assurance automobile du Québec (SAAQ), etc.? ☐ Yes ☐ No

G - PERSONAL INFORMATION MANAGEMENT

Desjardins Financial Security (DFS) handles the personal information it has on you in a confidential manner. DFS keeps this information on file so that you may benefit from group insurance services offered by the Company. This information is consulted solely by DFS employees who need to do so in the course of their work. 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 Financial Security, 200, rue des Commandeurs, Lévis, Québec, G6V 6R2. DFS 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 DFS.

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 Financial Security, 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.

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 Financial Security, C. P. 3950, Lévis (Québec) G6V 8C6