

## CLAIM FOR HEALTH CARE BENEFITS

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

### A - IDENTIFICATION

Policy or group or contract No.		Certificate No.		<b>IF GROUP IS SELF-ADMINISTERED the administrator must complete this section before the member fills out the form</b>		
Member's last name and first name		Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth YYYY MM DD		In force	Individual YYYY MM DD
		Number, street, apartment		Family YYYY MM DD		
City, province				Postal code		Terminated
Name of group or policyholder or employer				Administrator's signature		
				Date		

### B - COORDINATION OF BENEFITS

The coordination of benefits may entitle you to a reimbursement of up to 100% of your eligible expenses.

#### HOW TO SUBMIT A CLAIM WHEN THERE ARE TWO INSURERS

- The person who has the other insurance coverage must submit a claim to their own insurer first and then provide Desjardins Financial Security with detailed information about the benefits paid (information found on the explanation of benefits), as well as copies of any receipts.
- Claims for dependent children must first be submitted under the plan of the parent whose birthday (month and day) comes first in the calendar year.

Last name and first name of person who has the other insurance coverage		Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth YYYY MM DD	
Name of insurer <input type="checkbox"/> DFS <input type="checkbox"/> Other	Period of coverage From YY MM DD to YY MM DD	If the other insurer is DFS : Contract No.: _____ Certificate No.: _____		
Type of benefits:	<input type="checkbox"/> drugs	<input type="checkbox"/> dental care	<input type="checkbox"/> medical and paramedical care	<input type="checkbox"/> vision care <input type="checkbox"/> travel
Type of 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 coverage				

### C - INFORMATION ABOUT DEPENDENTS - for the period in which expenses were incurred (use one line per person).

I confirm that the persons designated below fit the definition of spouse and dependent child as specified in the contract under which this claim has been submitted.					<b>CHILDREN AGED 18 OR 21 OR OLDER (depending on the policy).</b> If your child has a functional impairment, please provide us with a medical certificate confirming your child's disability.	
Last name	First name	Relationship	Sex	Date of birth	Full-time student or with a functional impairment	Name of educational institution attended
		<input type="checkbox"/> Spouse <input type="checkbox"/> Child	<input type="checkbox"/> M <input type="checkbox"/> F	YYYY MM DD	<input type="checkbox"/> F. time Stud. <input type="checkbox"/> Funct. Imp. YYYY MM DD From _____ To _____	
		<input type="checkbox"/> Spouse <input type="checkbox"/> Child	<input type="checkbox"/> M <input type="checkbox"/> F	YYYY MM DD	<input type="checkbox"/> F. time Stud. <input type="checkbox"/> Funct. Imp. YYYY MM DD From _____ To _____	
		<input type="checkbox"/> Spouse <input type="checkbox"/> Child	<input type="checkbox"/> M <input type="checkbox"/> F	YYYY MM DD	<input type="checkbox"/> F. time Stud. <input type="checkbox"/> Funct. Imp. YYYY MM DD From _____ To _____	
In the case of a change of spouse, please indicate: <input type="checkbox"/> Start date of cohabitation: YY MM DD OR <input type="checkbox"/> Date of marriage: YY MM DD					Child born of this union? <input type="checkbox"/> No <input type="checkbox"/> Yes → Date of birth: YY MM DD	

### D - HEALTH SPENDING ACCOUNT - If you have this coverage, check the options 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.
  - I recognize 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.
1. I do not wish to use my Health Spending Account.
2. **Ineligible expenses** - I wish to use my Health Spending Account to cover the expenses that are not reimbursed under my group insurance.
3. **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. I will not submit a claim to my spouse's insurer (coordination of benefits).

## 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 twelve months after expenses are incurred.

## E - DIRECT DEPOSIT AND ELECTRONIC NOTICE SERVICE

- This service enables you to receive your health claim payments by direct deposit and to be informed by e-mail when your claim has been processed. **To enroll in this service**, please attach a specimen cheque marked "VOID" and provide your E-mail address:  
\_\_\_\_\_
- I would like to enrol in the Direct Deposit Service, but I do not wish to receive any email notices.
- For more details on this service or to make changes to it, please visit our Web site at [www.dfsgroupinsurance.com](http://www.dfsgroupinsurance.com).

## F - INFORMATION ABOUT THE CLAIM

Is the claim the result of:

- a work injury?  Yes  No
- a motor vehicle accident?  Yes  No

If yes: • Please note that the claim must first be submitted under your provincial workers' compensation plan or automobile insurance plan (if applicable in your province) before being submitted to your group plan.

YYYY MM DD

- Name of injured person: \_\_\_\_\_

Date of  
accident: \_\_\_\_\_

## G - OUT-OF-PROVINCE EXPENSES

Please include the original receipt itemizing all of your out-of-province expenses.

YYYY MM DD YYYY MM DD

Length of trip: from \_\_\_\_\_ to \_\_\_\_\_ Destination: \_\_\_\_\_ Amount claimed: \$ \_\_\_\_\_

Reason for trip:  Pleasure  Business  Receive care (please ensure that this type of trip is covered by your policy)

## H - 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.

## I - 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 \_\_\_\_\_

Area code + Number

Area code + Number

Telephone Nos:

Home:

Office:

Extension:

**Please send to: Desjardins Financial Security, C.P. 3950, Lévis, Québec, G6V 8C6**



100%