Desjardins Insurance
LIFE • HEALTH • RETIREMENT

200, rue des Commandeurs
Lévis (Québec) G6V 6R2

Print | Reset

CLAIM FORM
EXPENSES INCURRED OUTSIDE THE PROVINCE OF RESIDENCE OR COUNTRY

IDENTIFICATION

Insured's last name and first name	
Policy or group or contract No.	Certificate No.
Patient's last name and first name	Relationship

QUESTIONNAIRE - Please complete all the questions

Upon receipt of this information, we will be able to proceed with the assessment of your claim.

Date of departure from home province: _____ (YYYY MM DD)

Date on which return was originally planned: _____ (YYYY MM DD)

If return date differed from planned date, please indicate the actual date of return: _____

Reason for trip: ☐ Pleasure ☐ Business ☐ Receive care

Name of country visited and type of currency charged by the service provider(s):

_____

Were the services rendered as a result of an emergency? ☐ Yes ☐ No

Please describe the circumstances that necessitated the medical treatment:

Was the Assistance Service contacted at the time of the occurence? ☐ Yes ☐ No

Please indicate any other coverage that you have (i.e. private plan, credit card, etc.):

_____

Is your spouse insured under another insurance contract that provides benefits for travel expenses? ☐ Yes ☐ No

If so, please specify the name of company and the policy number: _____

Please indicate whether the cheque should be made payable to ☐ you or to ☐ the provider.

DECLARATION AND AUTHORIZATION TO COLLECT AND COMMUNICATE PERSONAL INFORMATION

All the information I have provided on the claim form is accurate and complete.

For the sole purpose of determining insurability, managing files and processing claims, I authorize Desjardins Financial Security Life Assurance Company (DFS) or its reinsurers: (a) to collect from any individual, legal entity or public or parapublic organization only the personal information they have about me that is needed to process my file. This information may be collected from third parties, including any health care professional or establishment, MIB, Inc., insurance and reinsurance companies, personal information brokers, investigation firms, the contract holder, my employer or my former employers; (b) to disclose to those individuals, legal entities or public or parapublic organizations only the personal information they have about me that is needed to manage my file; (c) to request, if applicable, an investigation report about me and to use the personal information contained in other files it may have that are now closed; (d) to disclose to my personal physician any medical information about me that was obtained during the evaluation of my file; (e) to disclose to other insurers or reinsurers any information about me that is relevant to determining my eligibility for insurance or for benefits; (f) to provide a brief report on my personal information, including my health information, to MIB, Inc. This authorization also applies to the collection, use and communication of personal information regarding my dependents or

(Name of deceased) _____, insofar as applicable to my claim. A photocopy of this authorization is as valid as the original.

Signed at _____ on _____, 20 _____.

Signature of insured or legal heir _____

Signature of any insured who is not the policyowner _____

Please send to: Desjardins Financial Security, 200, rue des Commandeurs, Lévis, Québec, G6V 6R2

100%