

C.P. 3950, Lévis (Québec) G6V 8C6

TO EXPEDITE PROCESSING OF YOUR CLAIM, PLEASE ANSWER ALL QUESTIONS.
(Missing or inaccurate information may result in handling delays, and the form may be returned to you for correction.)

A	Name of group GROUP HEALTH AND HOSPITALIZATION INSURANCE PLAN FOR FOREIGN CEGEPS AND PRIVATE COLLEGE STUDENTS	Contract No. N004	Certificate No.
	Member's last name	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth YY MM DD
	First name		
	Number, street, apartment		
	City, province	Postal code	

B	REFUND Do you wish the refund to be paid to the practitioner? <input type="checkbox"/> Yes <input type="checkbox"/> No
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C	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
	YY MM DD				\$
	YY MM DD				\$
	YY MM DD				\$
	YY MM DD				\$
	Name and address of attending physician (PLEASE PRINT) _____ _____ _____				
				Licence No.:	_____
				Telephone No.:	() _____
	Signature of attending physician			Date	

D	If expenses have been incurred during a trip outside Canada, please complete this section.				
	Date of departure	YY	MM	DD	
	Anticipated date of return to Canada	YY	MM	DD	
	Actual date of return to Canada	YY	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	YY	MM	DD	Type of accident <input type="checkbox"/> Automobile <input type="checkbox"/> Work <input type="checkbox"/> Other (specify):
	Amount claimed	Canadian currency	Other currency (Specify)	Has the bill been paid?	Amount
	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> In full <input type="checkbox"/> In part <input type="checkbox"/> No	\$ _____

E 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

IMPORTANT INFORMATION

- Send original receipts only (copies will not be accepted). Please keep copies for your records, the originals will not be returned. The explanation of benefits you will receive from us, along with copies of your receipts, are acceptable proof of expense for income tax purposes and coordination of benefits with other carriers.
- Claims MUST BE submitted no later than one year after expenses are incurred.

DRUG EXPENSES

- Attach your prescription drug receipts to this form.
- All receipts must contain the drug identification number (DIN) and the name of the drug.

MEDICAL/PARAMEDICAL EXPENSES (e.g.: chiropractor, podiatrist, physiotherapist)

If a medical recommendation is required under the terms of your contract, please include it.

Please attach an itemized statement or a receipt stating:

- patient's name
- practitioner's name
- practitioner's licence or registration number
- type of practitioner
- length of visit
- date(s) of visit(s)
- charge for each treatment

EQUIPMENT AND APPLIANCE EXPENSES

If required under the terms of your contract (see your booklet) provide the attending physician's written recommendation for the equipment or appliance prescribed, including the diagnosis, and a copy of the provincial-plan payment summary, if applicable.

Indicate the period of time the equipment will be required: from: _____ to: _____

F **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. DFS cannot use or communicate information contained in your file for commercial purposes without first receiving your written consent.

G **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 No.: ()

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