



**TO SPEED UP THE REVIEW OF YOUR CLAIM**

1. In legible writing, indicate **all the information** requested in the section entitled insured person's statement.
2. Make sure that all expenses incurred **during the insurance period** are listed on your claim.

**INSURED PERSON'S STATEMENT**

Name and address of insured person	Our file no.
	Postal code

State the name of your current employer (or your previous employer if you are retired) and that of your spouse, if applicable.

Are you presently (personally or through your spouse) the holder of another insurance that covers hospital, medical and paramedical expenses (that reimburses your medication)? If so, please indicate the name of the insurer and the policy number, if available:

Personally  yes  no

Your spouse  yes  no

Name of the insurer \_\_\_\_\_  
Policy number, identification number and/or file number \_\_\_\_\_

Name of the insurer \_\_\_\_\_  
Policy number, identification number and/or file number \_\_\_\_\_

Does this insurance cover medical expenses outside your province of residence?  yes  no

In the case of an accident, describe how it happened: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date of accident: Day Month Year

In the case of an illness, describe briefly the nature of the illness: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature of insured person: \_\_\_\_\_

**AUTHORIZATION FOR THE COLLECTION AND COMMUNICATION OF PERSONAL INFORMATION**

I authorize Desjardins Financial Security Life Assurance Company, strictly for the purposes of determining my insurability, managing my file and settling my claims 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, the MIB (formerly known as Medical Information Bureau), insurance companies, personal information officers or investigation agencies, the policyholder, my employer or former employers; (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, request an inquiry report about me, and also 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 minor children or

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

Signed at \_\_\_\_\_ on \_\_\_\_\_, 20 \_\_\_\_\_.

Signature of policyowner or legal heir \_\_\_\_\_

Signature of any insured who is not the policyowner \_\_\_\_\_