

**CLAIM PROCEDURE****IMPORTANT**

In order to process your request, we must ask you to complete this form and to **sign the *Mandate* section below and the *Signature and Authorization* section at the back**. This will enable us to file claims with the Régie de l'assurance maladie du Québec (RAMQ) on behalf of the insured.

**Note:** RAMQ does not return the original statements of account, invoices or receipts. Always keep a copy for your records.

**All documents must be sent to:** Travel Insurance Claims  
200, rue des Commandeurs  
Lévis (Québec) G6V 6R2

**MANDATE**

I, the undersigned, \_\_\_\_\_, hereby specifically mandate  
(please print)

the insurer, Desjardins Financial Security Life Assurance Company located at 200, rue des Commandeurs, Lévis (Québec) G6V 6R2, to:

1. Submit to RAMQ, in accordance with the laws and regulations applied by RAMQ, claims on my behalf for insured medical and hospital services rendered to me, my spouse or my children (family insurance)

at \_\_\_\_\_  
(city, country)

during my stay from \_\_\_\_\_ to \_\_\_\_\_  
(date) (date)

This section must be completed if other family members received medical attention during the trip.

**Family insurance:** For the purpose of family insurance, this mandate applies only to me, my spouse and my children, identified below:

Spouse: \_\_\_\_\_ Health Insurance Card No.: \_\_\_\_\_

Child: \_\_\_\_\_ Health Insurance Card No.: \_\_\_\_\_

Child: \_\_\_\_\_ Health Insurance Card No.: \_\_\_\_\_

2. Provide to RAMQ and receive from it all information, documents or any other proofs needed for the study, assessment and payment of these claims.
3. Receive from RAMQ the reimbursements made and payable to me, my spouse or my children (family insurance).

**I HEREBY AUTHORIZE** RAMQ to approve the claims submitted hereunder on my behalf and to act according to this mandate, as well as to forward to the insurer any information it may request concerning my status of Insured or that of my spouse and children.

**NOTE:** RAMQ also requires a signature on the back of the form to process this request.

\_\_\_\_\_  
**Signature of Insured**

\_\_\_\_\_  
Health Insurance Card Number

DO NOT WRITE IN THIS SPACE

**BENEFICIARY'S IDENTITY - The beneficiary is the person who has received the care.**

<b>HEALTH INSURANCE NUMBER</b>		LAST NAME		LAST NAME (AS APPEARING ON HEALTH INSURANCE CARD)				
LETTERS		FIGURES		FIRST NAME		DATE OF BIRTH YEAR MONTH DAY		SEX <input type="checkbox"/> M <input type="checkbox"/> F

**1 HOME ADDRESS IN QUÉBEC**

NO. STREET APT. LOCALITY

PROVINCE POSTAL CODE TELEPHONE NUMBER AT HOME AREA CODE TELEPHONE NUMBER AT WORK AREA CODE

**2 ADDRESS FOR CORRESPONDENCE OR PAYMENT, IF DIFFERENT THAN ADDRESS 1**

NO. STREET APT. LOCALITY

PROVINCE OR STATE AND COUNTRY POSTAL CODE TELEPHONE NUMBER AT HOME AREA CODE TELEPHONE NUMBER AT WORK AREA CODE

REIMBURSEMENT CHEQUE TO BE MAILED TO:  ADDRESS 1  ADDRESS 2

INQUIRY TO BE SENT TO:  ADDRESS 1  ADDRESS 2

**STAY OUTSIDE QUÉBEC**

<b>Period during which you received healthcare services</b>		If you spent other periods of <b>more than 21 consecutive days</b> outside Québec during the calendar year (January 1 to December 31), please specify:
Date of departure from Québec Year Month Day	Date of return to Québec <input type="checkbox"/> ACTUAL <input type="checkbox"/> PLANNED Year Month Day	
<b>REASON FOR STAY (CHECK ONE BOX ONLY)</b>		<b>1st STAY</b>
<input type="checkbox"/> Vacation or seasonal absence	Employer's name: _____	Departure day: Year Month Day   Return day: Year Month Day
<input type="checkbox"/> Work	Attach a written attestation from the educational institution showing the beginning and end dates, unless you have already done so.	<b>2nd STAY</b>
<input type="checkbox"/> Studies	Régie's authorization number: _____	Departure day: Year Month Day   Return day: Year Month Day
<input type="checkbox"/> Receipt of healthcare not available in Québec	Date of move: Year Month Day	<b>3rd STAY</b>
<input type="checkbox"/> Permanent move	<input type="checkbox"/> Within Canada <input type="checkbox"/> Outside Canada	Departure day: Year Month Day   Return day: Year Month Day
<input type="checkbox"/> Other	Specify: _____	

**HEALTHCARE SERVICES RECEIVED**

Give the reason for which you received these healthcare services

**IN THE CASE OF AN ACCIDENT, SPECIFY THE TYPE OF ACCIDENT**

Automobile  Work  Other (Specify) \_\_\_\_\_

Date of accident: Year Month Day

Describe the services received (examinations, X-rays, surgery, etc.). If you need more space, use a separate sheet.

WHERE DID YOU RECEIVE THESE SERVICES?

LOCALITY: \_\_\_\_\_ CANADIAN PROVINCE OR U.S. STATE: \_\_\_\_\_ COUNTRY: \_\_\_\_\_

If applicable, indicate the number of days you were hospitalized: \_\_\_\_\_

**REIMBURSEMENT**

Amount claimed: Canadian dollars  Other currency  SPECIFY: \_\_\_\_\_

Have you paid the bills?  No  Yes  In full  In part

AMOUNT PAID (enclose originals of receipts): \_\_\_\_\_

**SIGNATURE AND AUTHORIZATION**

I hereby declare, knowing that this declaration has the same value as though it were made under oath in accordance with the *Canada Evidence Act*, that the above information is accurate. I authorize the Régie to request from the health professional or institution any additional information that it may require. If this information is not provided free of charge, I agree to it being obtained at my expense.

If my application results from an automobile accident or a work accident, I authorize the RAMQ to provide the SAAQ or the CSST with a copy of any documents I may send to or receive from the Régie.

NAME OF PERSON SIGNING THIS FORM, IF OTHER THAN THE APPLICANT: \_\_\_\_\_

RELATIONSHIP TO APPLICANT (FATHER, MOTHER, SPOUSE, GUARDIAN, ETC.): \_\_\_\_\_

SIGNATURE: \_\_\_\_\_

YEAR MONTH DAY