Desjardins Insurance
Life • Health • Retirement

Case postale 3800
Lévis (Québec) G6V 0S1
www.desjardinslifeinsurance.com/send
All provinces or territories – except Quebec: 1-800-278-0669
Quebec: 1-888-558-5525

Individual Insurance

Claim for benefits following an accident

Please complete the following 3 steps:

1. Complete sections A and B, read sections C and D and sign section E.
2. Have the physician's statement completed and signed.
3. Provide proof of payment for any additional expenses provided for under the contract.

A. Identification of policyholder

Contract number

Last name	First name	Date of birth (YYYY-MM-DD)

Address – No., street, apt.	City	Province/Terr.	Postal code

10-digit phone number (résidence)

Do you (yourself or with your spouse) have other insurance that covers hospital, medical and paramedical expenses? If yes, write the name of the insurer and the policy number (if available):

Yourself	Your spouse
☐ Yes ☐ No	☐ Yes ☐ No
Insurer's name: _____	Insurer's name: _____
Policy No.: _____	Policy No.: _____

Spouse's name (if applicable)

B. Policyholder's statement

Last name of the injured	First name	Date of birth (YYYY-MM-DD)	Sex ☐ F ☐ M

Nature of injury

Name of school attended, if applicable (append proof of attendance)

Name and address of physicians consulted

Place and address of the first consultation

Date of hospitalization (YYYY-MM-DD)	Name of hospital

Date of accident (YYYY-MM-DD)	Time of accident :	Place of accident	Type of accident (motor vehicle, hockey, etc.)

If it was a motor vehicle accident, were you the driver? ☐ Yes ☐ No

How did the accident happen?

Last name of the injured	First name	Date of birth (YYYY-MM-DD)

C. Consent related to the management of your personal information by Desjardins Group

This consent applies to the policyholder and the injured.

1. Management of your personal information

To serve you on a daily basis and meet our legal obligations, we need to collect, use and disclose information about you. For more details, see Desjardins Group's Privacy Policy at www.desjardins.com/privacy-policy.

You may be asked for specific consent to ensure that Desjardins Insurance can deliver or continue to deliver service. This will be done in compliance with Desjardins Group's Privacy Policy.

Desjardins Insurance handles all your personal information confidentially. Your information will be accessed only by employees who require it to complete their tasks.

2. Your rights

You can:

- See the personal information Desjardins Group has about you
- Correct any information that's incomplete, ambiguous or not relevant

To find out how, see Desjardins Group's Privacy Policy.

3. Collection or transfer of your personal information outside of Canada

Desjardins Insurance uses service providers located outside of Canada to perform certain specific activities in its normal course of business. As such, personal information may be collected in and/or transferred to another country and be subject to the laws of that country.

For information about our policies and practices regarding the collection and transfer of personal information outside of Canada, see Desjardins Group's Privacy Policy. You can also obtain this information, or ask any questions you might have, by calling us a 1-800-463-7870.

By signing this form, you:

- Acknowledge that you've looked at Desjardins Group's Privacy Policy, which is available at www.desjardins.com/privacy-policy
- Authorize Desjardins Group to collect, use and disclose your personal information based on the conditions outlined in the policy and applicable regulations
- Acknowledge and accept that this consent takes precedence over any other consent you've previously signed
- Acknowledge that this consent remains valid for as long as you have a business relationship with a Desjardins Group component

⚠ Please sign the last page of this form

D. Consent related to the information Desjardins Insurance gets about you

This consent applies only to the injured.

1. Why Desjardins Insurance needs your consent

Your consent allows us to collect, use and disclose the personal information we require to:

1. Analyze your insurance applications
2. Manage your file while you're covered under the insurance
3. Process claims

Your consent also allows us to do the following, as required:

- Look at information in any old insurance file you may have with Desjardins Insurance
- Ask a personal information broker to provide us with an investigation report about you, if necessary
- Send a summary of your personal information, including health-related information, to MIB, LLC (see text box below), after analyzing an insurance application you've submitted

  MIB, LLC is an organization that operates a database allowing insurance companies in Canada and the United States to collect and disclose information about their clients.

- Send your doctor any medical information that we obtained about you when analyzing your insurance applications or claims, so they can share it with you
- Provide insurers and reinsurers with any relevant information (medical test results, etc.), so they can assess an insurance application you've submitted

By giving your consent to us, you also authorize our reinsurers to collect, use and disclose your personal information the same way we would. Our reinsurers are companies that insure us, Desjardins Insurance.

Last name of the injured	First name	Date of birth (YYYY-MM-DD)

2. Who your personal information will be collected from or disclosed to	You give your consent for the collection and disclosure of the necessary information with you, but also with other people and organizations. These people and organizations include: • MIB, LLC • Healthcare professionals or establishments (doctors, hospitals, clinics, etc.) • Healthcare providers • Paramedical firms • Public or parapublic organizations • Insurance companies other than Desjardins Insurance • Reinsurers • Your employer or a former employer • The policyowner (also called policyholder or contract holder), if you aren't that person • Other Desjardins components, if they're involved in the insurance • A personal information broker or an investigation firm
3. If the application concerns your children	You authorize us to collect, use and disclose the necessary personal information about them, if they're under age 14 (Quebec) or under age 16 (all other provinces and territories).

By signing this form, you:

- Authorize Desjardins Insurance and its reinsurers to collect, use and disclose your personal information based on the conditions outlined in this section, the applicable regulations and Desjardins Group's Privacy Policy. You can consult the policy at www.desjardins.com/privacy-policy.
- Declare that the information you have provided here is complete and accurate.

E. Signatures

x _____ Signature of the policyholder

_____ Date (YYYY-MM-DD)

x _____ Signature of the injured

_____ Date (YYYY-MM-DD)

› If the person is a minor child who is under age 14 (Quebec) or under age 16 (all other provinces and territories), a parent, guardian or legal representative must sign for them and complete the green box below

Person signing for the minor child:

_____

First and last names (please print)

Relationship to the minor child:

☐ Parent (father or mother) ☐ Guardian (Quebec)

☐ Legal representative (all provinces and territories other than Quebec)

Print Reset

Desjardins Insurance
Life • Health • Retirement

Claim for benefits following an accident

Declaration of the attending physician

Fees charged for this statement are to be paid by the claimant.

A. Information about the injured person – Section to be completed by the insured

Last name	First name	Date of birth (YYYY-MM-DD)

B. General information

Date of accident (YYYY-MM-DD)	Date of the injury's diagnosis (YYYY-MM-DD)

At the time of the accident, was the insured under the effect of:

Medication? ☐ Yes ☐ No

Narcotics? ☐ Yes ☐ No

Alcohol? ☐ Yes ☐ No

If so, please provide us the test results.

Diagnosis of an injury

Fracture or rupture	Specify the bone or canal in question (attach a copy of the X-ray report)					
Dismemberment or loss of use	Date (YYYY-MM-DD)	Description of amputation or of loss of use				
	Level of amputation or percentage of loss of use					
	Is the loss:	Total? ☐ Yes	☐ No	Permanent?	☐ Yes	☐ No
Disability	Date (YYYY-MM-DD)	Description				
	To the best of my knowledge, this patient was totally disabled from (YYYY-MM-DD)			to (YYYY-MM-DD)		
Loss of sight	Date (YYYY-MM-DD)					
	What is the visual field in each eye? Right eye	Left eye		Is the loss of sight total and permanent? Right eye ☐ Yes ☐ No	Left eye ☐ Yes ☐ No	

Was the accident the cause of:

the injury?	the amputation or loss of use?	disability?	the loss of sight?
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

If not, explain:

Other attending physicians

Name	Address	Date (YYYY-MM-DD)

Hospital or other institutions where care was rendered

Name	Address	Date (YYYY-MM-DD)

C. Identification of physician

Name and address of physician (PLEASE PRINT)

Specialty	Permit number
Signature of physician	Date (YYYY-MM-DD)