

## **CLAIM FOR DENTAL CARE EXPENSES**

DENTIST INFORMATION						
Last name and first name	Membe	r number	Telephone number			
Address - No., street, suite	City	Province	e Postal code			
CLAIM INFORMATION Predetermination Bill						
IMPORTANT: If the claim is for dental treatment due to an accident please refer to section I. If the treatment requires more than one session, the date of treatment must be the date on which the treatment terminates or the insertion date.						
Last name and first name of the patient	Date of	YY MM DD	ationship to the member  Spouse Daughter Son			
Treatment date YY MM DD Tooth no. Procedure Tooth surface expense		Diagnosis - This section is				
		THIS IS AN ACCURATE S	TATEMENT OF SERVICES PERFORMED			
		AND FEES CHARGED. Signature				
		of dentist:				
	Total fee claimed:	Date:				
ASSIGNMENT OF BENEFITS						
If benefits are to be assigned to the dentist, you must fill out this section each time you complete this form.  I acknowledge that certain expenses referred to in this claim may not be covered by the insurer or may exceed the maximum to which I am entitled. I also acknowledge that I am responsible for paying these expenses. I assign my benefits payable to the dentist designated on this form and authorize Desjardins Financial Security Life Assurance Company, hereinafter Desjardins Insurance, to pay this dentist directly.  Signature of member:  Date:						
MEMBER INFORMATION To be completed by the member. If you don't know your group no. or certificate no., please click ?.  Group name and group no.  Certificate no. or student identification no.						
Member's last name and first name		Sex	Date of birth MM DD			
Address - No., street, apartment	Address - No., street, apartment City Province Postal code					
Complete only if you are claiming expenses incurred for your dependent children aged 21 and over. Remember to include the information for the period in which the expenses were incurred for your child. If your child has a functional impairment, please provide us with a medical certificate confirming your child's disability.						
Has a functional impairment		YY	YY MM DD YYYY MM DD			
Full-time student - Name of educational institution attended		Period: From	То			
COORDINATION OF BENEFITS  To be completed by the member. This section must be completed if the claim is for yourself, a spouse or child, and if your spouse is insured under another insurance plan that provides dental care benefits.						
Last name and first name of person who has the other insurance	e plan	Sex □ M	Date of birth MM DD			
Name of insurer ☐ Other ☐ Desjardins Insurance - Contract no.:	Certificate no.:	Period of coverage  YYYY  From	DD YYYY MM DD			
Type of dental coverage:	☐ Single-parent ☐ Family					
Last name and first name of the dependents covered under this other insurance plan						
Claims MUST be submitted no later than 90 days after the end of the policy year in which the expenses were incurred or 90 days after the end of your coverage, whichever comes first.						
Please sign section H and send the form to: Desjardins Insurance, C.P. 3950, Lévis (Québec) G6V 8C6						

For specific details regarding your plan, please visit studentcare.ca.

DIRECT DEPOSIT SERVICE Attach a void cheque or provide your bank information below to sign up for direct deposit.							
Tra	nsit/branch no.	Institution no.	Account no.	NOID			
You	ır email address (mandatory)			Branch no. Institution no. Account no.			
Once registered, your reimbursements for health care services will be deposited into this bank account. A notification email will be sent once your claims have been processed, and the explanation of benefits will be posted online rather than mailed. You must be registered on the secure site to consult your explanation of benefits. To register, go to desjardinslifeinsurance.com/planmember.							
Desjardins Insurance, is not responsible for the accuracy of the banking information you enter and for verifying that the due amounts are deposited into your account.							
PE	RSONAL INFORMATION	I MANAGEMENT					
Desjardins Insurance handles the personal information it has on you in a confidential manner. Desjardins Insurance keeps this information on file so that you may benefit from group insurance services offered by the Company. This information is consulted solely by Desjardins Insurance employees who need to do so in the course of their work. Desjardins Insurance may compile anonymized personal information for statistical and informational purposes. Desjardins Insurance may also communicate with plan members to provide them with optimal health management. 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 Insurance, 200, rue des Commandeurs, Lévis, Québec, G6V 6R2. Desjardins Insurance 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 Desjardins Insurance.							
DECLARATION AND AUTHORIZATION FOR THE COLLECTION AND COMMUNICATION OF PERSONAL INFORMATION							
I understand that I am responsible for the total cost of the treatment. 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 Insurance, 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.							
I also authorize Desjardins Insurance to release the information regarding this claim to Studentcare for benefits administration. 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.							
Sig	nature of the member:	the member: Date:					
Tele	ephone nos: Home:		Office:	Extension:			
DE	NTAL TREATMENT DUE	TO AN ACCIDENT					
•	TO BE COMPLETED BY T	THE MEMBER  YYYY MM DD					
	Date of the accident: Location of the accident:						
	How did the accident occur?						
	If the claim is the result of a work injury or a motor vehicule accident, please note that the claim must first be submitted to your provincial automobile insurance (if applicable in your province) or occupational health and safety plan before being forwarded to your insurer.						
•	TO BE COMPLETED BY THE <u>DENTIST</u>						
Is it an accidental injury to a healthy and natural tooth? $\square$ Yes $\square$ No							
	Diagnosis and clinical description prior to the accident:						

Please send to: Desjardins Insurance, C. P. 3950, Lévis (Québec) G6V 8C6

Preoperative X-rays are required for the study of dental treatment due to an accident. They will be returned to the attending dentist as soon as possible.