Desjardins Financial Security®
C. P. 3950
Lévis (Québec) G6V 8C6

GROUP INSURANCE - HEALTH CLAIMS

CLAIM FOR TUITION EXPENSES
PHYSICIAN STATEMENT

IDENTIFICATION OF STUDENT - Any charge for the completion of this form is the member's responsability.

First name and last name of student			Telephone no. ( ) -
Group no.	Student ID no. (The student ID number can be found on your student ID card)	Sex ☐ M ☐ F	Date of birth YYYY MM DD
Address - no., street, apt.	City	Province	Postal code
Policyholder name			

PHYSICIAN OR DENTIST STATEMENT

Desjardins Financial Security Life Assurance Company will use the information in this form to determine your patient's eligibility for reimbursement of tuition and related expenses as a result of disability. It is very helpful in facilitating a timely comprehensive informed adjudication decision to have your full clinical notes from the date of disability and any psychiatric/counsellor consultation reports for our review. Please include or indicate reasons for not including the requested information.

1. Diagnosis (including complications). If psychiatric, complete section 2

1.1 Primary: _____

1.2 Secondary: _____

1.3 Findings (please enclose a copy of current x-rays, EKGs, laboratory data, blood pressure and any other relevant clinical findings): _____

2. Mental or nervous impairment (if applicable)

2.1 What symptoms is this patient displaying that indicate a mental impairment exists? _____

2.2 Has there been a psychiatric referral? ☐ No ☐ Yes - Name of psychiatrist: _____

2.3 DSM-IV diagnosis

Supporting data
Please describe the symptoms (severity and frequency), that support each axis of your diagnosis.

Axis I: _____

Axis II: _____

Axis III: _____

Axis IV: _____

Axis V - Current GAF score:

3. Treatment dates

3.1 Date of first visit for current condition: Y Y Y Y M M D D

3.2 Date of latest visit: Y Y Y Y M M D D

3.3 Frequency of visits: ☐ Weekly ☐ Monthly ☐ Other (specify): _____

3.4 Date patient's condition first prevented them from attending all classes: Y Y Y Y M M D D

3.5 Date of in-patient admission: Y Y Y Y M M D D

3.6 Date of discharge: Y Y Y Y M M D D

3.7 Date of out-patient treatment: Y Y Y Y M M D D

3.8 Name of hospital: _____

PLEASE COMPLETE THE BACK OF THE FORM.

4. Nature of treatment

4.1 Medications (dose, frequency, date prescribed): _____

4.2 Surgeries (including dates): _____

4.3 Other (including frequency): _____

4.4 Is patient following recommended treatment program? ☐ Yes ☐ No (please elaborate): _____

5. Progress

5.1 Has patient: ☐ Recovered ☐ Improved ☐ Not improved ☐ Retrogressed

5.2 Current status: ☐ Ambulatory ☐ House confined ☐ Bed confined ☐ Hospital confined

6. Restrictions and limitations

			HOURS AT ONE TIME					TOTAL HOURS DURING THE DAY				
			< 1	< 1-2	< 2-4	4-6	6-8	< 1	< 1-2	< 2-4	4-6	6-8
6.1	Stand	☐ No restriction	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
6.2	Walk	☐ No restriction	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
6.3	Walk on uneven surfaces	☐ Yes ☐ No	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
6.4	Sit	☐ No restriction	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
6.5	Drive	☐ No restriction	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
6.6	This patient can lift/carry a maximum of:	kgs	0	5	9	14	18	23	27	32	36	41+
		lbs	0	10	20	30	40	50	60	70	80	90+
	☐ No restriction	☐ Repetitively: how much?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
		☐ Occasionally: how much?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

6.7 Please indicate in the space provided if this patient is able to perform the following actions: Frequently (F), Occasionally (O), or Not at all (N):

Drive: Bend: Squat: Kneel: Climb: Reach (above shoulders): Reach (below shoulder):

6.8 How is your patient limited from attending all classes? What prevents them from returning to college or university? _____

7. Plans to return to school

7.1 Prognosis for improvement or recovery: _____

7.2 Date patient expected to be able to return to school: Y Y Y Y M M D D

7.3 If unknown, please indicate the next follow-up date: Y Y Y Y M M D D

7.4 Has a return to school been discussed with the patient? ☐ Yes ☐ No

7.5 Please elaborate on time frames and patient's response: _____

8. Comments

Is there any other information you wish to add that will give us a better understanding of your patient's condition or treatment requirements?

9. Identification of physician

Last name and first name (PLEASE PRINT)	Telephone no.: ( ) -
Specialty	License no.

Address - no., street, suite	City	Province	Postal code

Signature of physician **Date**

VERY IMPORTANT

PLEASE SEND THIS FORM DULY COMPLETED ALONG WITH THE "CLAIM FOR TUITION EXPENSES - STUDENT STATEMENT" FORM (ASEQ: NO. 12195E, STUDENTCARE.NET/WORKS: NO. 12195E01) TO: DESJARDINS FINANCIAL SECURITY LIFE ASSURANCE COMPANY, C. P. 3950, LÉVIS, QUÉBEC, G6V 8C6

PRINT NEW REQUEST