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

GROUP INSURANCE - HEALTH CLAIMS

CLAIM FOR TUITION EXPENSES
STUDENT STATEMENT

PLEASE READ THE FOLLOWING CAREFULLY BEFORE COMPLETING THIS FORM.

- **Please attach to this form original receipts for your book purchases as well as fees/expenses that are mandatory, non-negotiable and non-refundable and that you no longer use following withdrawal from college or university (copies will not be accepted). Keep copies for your records, as the originals will not be returned.**
- **The explanation of benefits you receive from us, along with copies of your receipts, are acceptable proof of expense for income tax purposes and coordination of benefits with other carriers.**
- **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.**
- **Have your physician complete the "Claim for Tuition Expenses" form (no. 12194E).**
- **For specific details regarding your plan, please visit www.ihaveaplan.ca.**

A - Identification of student

Last name and first 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			

B - Disability due to sickness or injury

1. Please describe the nature of your condition: _____

2. When did you first receive treatment from a physician: _____
   YYYY MM DD

3. When were you first unable to attend classes?

C - Identification of physicians or healthcare providers

Please provide the name and address of each physician or other healthcare provider involved in your medical care.

Last name and first name of physician or healthcare provider (PLEASE PRINT)		Telephone no. ( ) -
Specialty		License no.
Address – no., street, apt.	City	Province / Postal code
Date of latest visit YYYY MM DD	Frequency of visits ☐ Weekly ☐ Monthly ☐ Other (specify):	Date of next visit YYYY MM DD

Last name and first name of physician or healthcare provider (PLEASE PRINT)		Telephone no. ( ) -
Specialty		License no.
Address – no., street, apt.	City	Province / Postal code
Date of latest visit YYYY MM DD	Frequency of visits ☐ Weekly ☐ Monthly ☐ Other (specify):	Date of next visit YYYY MM DD

PLEASE COMPLETE THE BACK OF THE FORM.

D - Treatment

1. Please describe your current treatment (surgery, physiotherapy, counselling): _____

_____

2. If you are taking any medications, please provide the following details:

Name of medication	Dosage	Date started YYYY MM DD	Purpose of medication

3. If you are scheduled for any further referrals, blood tests, X-rays, examinations, surgery, or any other type of investigation or treatment, please provide details here.

Type of referral, investigation or treatment	Date scheduled YYYY MM DD	Healthcare provider or facility?

3. Please describe your current condition: ☐ Recovered ☐ Improved ☐ Unchanged ☐ Deteriorating

4. Please list and comment on only the symptoms which affect your ability to attend classes.

Specific symptom	If applicable, please comment on location, duration, frequency and severity of this symptom

E - Return to school plans

1. Have you returned to college or university part-time? ☐ Yes ☐ No If yes, when? YYYY MM DD _____

2. Have you returned full-time? ☐ Yes ☐ No If yes, when? YYYY MM DD _____

3. If you have not returned what are your current thoughts about your readiness to do so?

☐ I do not anticipate returning on either a part-time or full-time basis.

☐ I anticipate returning part-time on or around this date: YYYY MM DD _____

☐ I anticipate returning full-time on or around this date: YYYY MM DD _____

F - Comments

Is there any other information you wish to add that will give us a better understanding of your condition? _____

_____

_____

G - Personal information management

Desjardins Financial Security Life Assurance Company (DFS) handles the personal information it has on you in a confidential manner. DFS keeps this information on file so that you may benefit from group insurance services offered by the Company. This information is consulted solely by DFS employees who need to do so in the course of their work. 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 Financial Security Life Assurance Company, 200, rue des Commandeurs, Lévis, Québec, G6V 6R2. DFS 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 DFS.

H - 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 Financial Security Life Assurance Company, 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 and 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 DFS to release the information regarding this claim to STUDENTCARE.NET/WORKS 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.

Signature of student **Date**

VERY IMPORTANT	**PLEASE HAVE THE "PHYSICIAN STATEMENT" FORM (NO. 12194E) FILLED OUT AND FORWARD COMPLETED FORMS TO: DESJARDINS FINANCIAL SECURITY LIFE ASSURANCE COMPANY, C. P. 3950, LÉVIS (QUÉBEC) G6V 8C6**

PRINT NEW REQUEST