Desjardins Insurance
LIFE • HEALTH • RETIREMENT

C. P. 3950
Lévis (Québec) G6V 8C6

GROUP INSURANCE - HEALTH CLAIMS

CLAIM FOR DENTAL CARE EXPENSES

DENTIST INFORMATION

☐ Predetermination ☐ Bill

Last name and first name	Member no.	Telephone no. ( ) -
Address - No., street, suite	City	Province / Postal code

CLAIM INFORMATION

IMPORTANT: If the claim is for dental care subsequent to an accident, please see the reverse side. 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 birth YYYY MM DD	Relationship to the member ☐ Spouse ☐ Daughter ☐ Son

Date of treatment Year Month Day	Tooth no.	Procedure code	Tooth surface	Laboratory expenses	Dentist's fees	Total charge
			Total fee claimed:			

This section is reserved for the dentist's diagnosis.

THIS IS AN ACCURATE STATEMENT OF SERVICES PERFORMED AND FEES CHARGED.

Signature of dentist _____

Date:

MEMBER INFORMATION - To be completed by the member. To expedite processing of your claim, please answer all questions.

Name of group	Group no.	Student ID no. (The student ID number can be found on your student ID card)
Society of Graduate Students at the University of Western Ontario	**Q1109**	

Last name and first name of member	Sex ☐ M ☐ F	Date of birth YYYY MM DD
Address - No., street, apt. / City / Province / Postal code		

Complete only if you are claiming expenses incurred for your dependent children aged 21 or older. 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.

Full-time student or with a functional impairment: ☐ Funct. imp. ☐ Full-time stud.: From YYYY MM DD To YYYY MM DD	Name of educational institution attended

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 contract that provides dental benefits.

Last name and first name of person who has the other insurance coverage	Sex ☐ M ☐ F	Date of birth YYYY MM DD

Name of insurer ☐ DFS ☐ Other	Period of coverage From YYYY MM DD To YYYY MM DD	If the other insurer is DFS: Contract no.: Certificate no.:

Type of dental coverage: ☐ Individual ☐ Couple ☐ Single-parent ☐ Family

Last name and first name of the dependents covered under this other insurance coverage

DIRECT DEPOSIT AND ELECTRONIC NOTICE SERVICE

With these services, your health claim payments are automatically deposited into your bank account, and you receive an e-mail that gives you access to your explanation of benefits online once your claim has been processed.

☐ I would like to enroll in the Direct Deposit Service and Electronic Notice Service.
To enroll in this service, please attach a specimen cheque marked "VOID" and provide your e-mail address:

_____

☐ I would like to enroll in the Direct Deposit Service, but I do not wish to receive any e-mail notices.

For more details on this service or to make changes to it, please visit our website at www.dfsgroupinsurance.com.

PLEASE COMPLETE THE BACK OF THE FORM.

IMPORTANT INFORMATION

- **Send original receipts only (copies will not be accepted). Please keep copies for your records, the originals will not be returned. The explanation of benefits you will 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.**
- **For specific details regarding your plan, please visit www.ihaveaplan.ca.**

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 the insurer to pay this dentist directly.

Signature of member: **Date:**

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.

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 healthcare 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 Financial Security Life Assurance Company 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 member _____ **Date** _____

Telephone nos: Home: ( ) - Office: ( ) - Extension:

DENTAL CARE SUBSEQUENT TO AN ACCIDENT

TO BE COMPLETED BY 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 DENTIST.

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

Is it an accidental injury to a healthy and natural tooth? ☐ Yes ☐ No

Diagnosis and clinical description prior to the accident: _____

_____

PRINT NEW REQUEST

Please send to: Desjardins Financial Security Life Assurance Company, C. P. 3950, Lévis (Québec) G6V 8C6