Desjardins Insurance
LIFE • HEALTH • RETIREMENT

C. P. 3950
Lévis (Québec) G6V 8C6

GROUP INSURANCE - HEALTH CLAIMS

CLAIM FOR HEALTH CARE BENEFITS

TO EXPEDITE PROCESSING OF YOUR CLAIM, PLEASE ANSWER ALL QUESTIONS.

A - IDENTIFICATION

Group no.	Student ID no. (The student ID number can be found on your student ID card).
Q1110	

Last name and first name of member | Sex ☐ M ☐ F | Date of birth YYYY MM DD

No., street, apt.

City | Province | Postal code

Name of group

Student Union Society of the University of the Fraser Valley (SUS)

B - COORDINATION OF BENEFITS

The coordination of benefits may entitle you to a reimbursement of up to 100% of your eligible expenses.

HOW TO SUBMIT A CLAIM WHEN THERE ARE TWO INSURERS:

1. The person who has the other insurance coverage must submit a claim to their own insurer first and then provide Desjardins Financial Security Life Assurance Company (DFS) with detailed information about the benefits paid (information found on the explanation of benefits), as well as copies of any receipts.
2. Claims for dependent children must first be submitted under the plan of the parent whose birthday (month and day) comes first in the calendar year.

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 benefits: ☐ Drugs ☐ Dental care ☐ Medical and paramedical care ☐ Vision care ☐ Travel

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

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

C - INFORMATION ABOUT DEPENDENTS - For the period in which expenses were incurred.

I confirm that the persons designated below fit the definition of spouse and dependent child as specified in the contract under which this claim has been submitted.
Use one line per person.

CHILDREN AGED 21 OR OLDER
If your child has a functional impairment, please provide us with a medical certificate confirming your child's disability.

Last name	First name	Relationship	Sex	Date of birth	Full-time student or with a functional impairment	Name of educational institution attended
		☐ Spouse ☐ Child	☐ M ☐ F	YYYY MM DD	☐ F. time Stud. ☐ Funct. Imp. YYYY MM DD From To	
		☐ Spouse ☐ Child	☐ M ☐ F	YYYY MM DD	☐ F. time Stud. ☐ Funct. Imp. YYYY MM DD From To	
		☐ Spouse ☐ Child	☐ M ☐ F	YYYY MM DD	☐ F. time Stud. ☐ Funct. Imp. YYYY MM DD From To	

D - DIRECT DEPOSIT AND ELECTRONIC NOTICE SERVICE

- This service enables you to receive your health claim payments by direct deposit and to be informed by e-mail when your claim has been processed.
  To enroll in this service, please attach a specimen cheque marked "VOID" and provide your e-mail address:

  _____

- ☐ I would like to enrol 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.**

E - INFORMATION ABOUT THE CLAIM

Is the claim the result of:

• a work injury? ☐ **Yes** ☐ **No** **• a motor vehicle accident?** ☐ **Yes** ☐ **No**

If yes: • Please note that the claim must first be submitted under your provincial workers' compensation plan or automobile insurance plan (if applicable in your province) before being submitted to your group plan.

• Name of injured person:

Date of accident: YYYY MM DD

F- 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.

G - DECLARATION AND AUTHORIZATION FOR THE COLLECTION AND COMMUNICATION OF PERSONAL INFORMATION

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, 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:

PRINT NEW REQUEST

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