Desjardins Insurance
Life • Health • Retirement

Case postale 520, succ. Lévis
Lévis (Québec) G6V 7E2
www.desjardinslifeinsurance.com

Accirance

Claim

Instructions

If you're making a claim for:

A fracture: Complete sections A, B and C, and attach a copy of the radiology report.

A hospitalization, disability,[1] loss of use, dismemberment or coma:[2]
Complete sections A, B, C and D.

Any other reason, except for death: Complete sections A, B and C, and attach medical confirmation of the injury.

Death: This isn't the form you need to complete. Call us at **1-877-886-5042**.

[1] For students aged 16 to 24 inclusive.
[2] For Accirance Select contracts only.

After you've completed the form

Sign it and send it to:

Desjardins Insurance
Case postale 520, succ. Lévis
Lévis (Québec) G6V 7E2

Questions?

Call us at **1-877-886-5042**
(Monday to Friday from 8:00 a.m. to 5:00 p.m.)

What you also need to know

- To receive your payment by **direct deposit**, please send us a void cheque.
- We may ask you for more information.
- If you provide documents, we won't send them back to you unless you ask.

A. About you (the contract holder)

Last name	First name	Contract number	
Address – Number, street and apartment	City	Province	Postal code

B. Contract holder's statement

1. About the injured person

Last name	First name	Date of birth (YYYY-MM-DD)	Age	Sex
				☐ F ☐ M

Does the injured person have other accident coverage (group, individual or government)?

☐ Yes ☐ No **If Yes**, please provide the information below.

☐ Group insurance →	Name of insurer	Contract number	Certificate number
☐ Individual insurance →	Name of insurer	Contract or policy number	
☐ Government insurance →	Name of government agency		

If student, provide name of school

2. About the accident

Date (YYYY-MM-DD)	Time ☐ AM ☐ PM	Place

Detailed description (type of accident and circumstances) – If there isn't enough space, use a separate sheet of paper, and be sure to sign and date it.

Nature of injuries – If it's a fracture, please specify whether it involves the larynx, the trachea or a bone (indicate which bone).

Was the injured person hospitalized?	Dates (YYYY-MM-DD)		Name of hospital
☐ Yes ☐ No **If Yes** →	From:	To:	

Names and addresses of doctors

C. Authorization to collect and communicate personal information

For the sole purpose of determining insurability, managing files and processing claims, I authorize Desjardins Insurance or its reinsurers:

a) to collect from any individual, legal entity or public or parapublic organization only the personal information they have about me that is needed to process my file. This information may be collected from third parties, including any health care professional or establishment, MIB, Inc., insurance and reinsurance companies, personal information brokers, investigation firms, the contract holder, my employer or my former employers;

b) to disclose to those individuals, legal entities or public or parapublic organizations only the personal information they have about me that is needed to manage my file;

c) to request, if applicable, an investigation report about me and to use the personal information contained in other files it may have that are now closed;

d) to disclose to my personal physician any medical information about me that was obtained during the evaluation of my file;

e) to disclose to other insurers or reinsurers any information about me that is relevant to determining my eligibility for insurance or for benefits;

f) to provide a brief report on my personal information, including my health information, to MIB, Inc.

This authorization also applies to the collection, use and communication of personal information regarding my dependents, insofar as applicable to my claim.

A photocopy of this authorization is as valid as the original.

X _____ _____
Contract holder's signature | Date (YYYY-MM-DD)

X _____ _____
Injured person's signature (if 14 or older) | Date (YYYY-MM-DD)

D. Doctor's statement – You don't need to have this section completed if you're submitting a claim for a fracture only. You're responsible for paying any fees the doctor may charge to complete it.

Date of first visit (YYYY-MM-DD)	Injury diagnosis

If the injured person was hospitalized

Admission			Discharge		
Date (YYYY-MM-DD):	Time:	☐ AM ☐ PM	Date (YYYY-MM-DD):	Time:	☐ AM ☐ PM

If the injured person was disabled

Cause	Period (YYYY-MM-DD)	
	From:	To:

Is the accident described in **section B** the reason for the: → Hospitalization? ☐ Yes ☐ No Disability? ☐ Yes ☐ No

Doctor's name and address (please print)

X _____ _____
Doctor's signature | Date (YYYY-MM-DD)

Print Reset