

Case postale 3800 Lévis (Québec) G6V 0S1 www.desjardinsifieinsurance.com/send All provinces or territories – except Quebec: 1-800-278-0669 Quebec: 1-888-558-5525

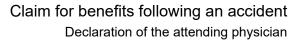
PLEASE COMPLETE THE FOLLOWING 3 STEPS:

1. Complete sections A, B and C and sign the Authorization for the collection and communication of personal information on page 3.

Claim for benefits following an accident

2. Have the physician's statement completed and signed.

Provide proof of payment for any add	ditional expenses p	rovided for under the	e contract.					
					Contract number			
A. IDENTIFICATION OF POLICYHO	LDER							
Last name			First name		Date of birth			
					YYYY-MM-DD			
Address – No., street, apt.		City		Province	Postal code			
Telephone number (Area code + number)	Home:							
Do you (yourself or with your spouse) have other insurance that covers hospital, medical and paramedical expenses? If yes, write the name of the insurer and the policy number (if available):								
Yourself Yes No	f Yes No Your spouse Yes No							
Insurer's name			Insurer's name	's name				
Policy No.			Policy No.					
Spouse's name (if applicable)								
B. POLICYHOLDER'S STATEMENT Last name of the injured		First name		Date of birth	Sex			
				YYYY-MM-DD	□F □M			
Nature of injury				111111111111111111111111111111111111111				
Name of school attended, if applicable (append proof of attendance)								
Name and address of physicians consulted								
Place and address of the first consultation								
Date of hospitalization	Name of hospital							
YYYY-MM-DD								
Date of accident	Time of accident	Place of accide	ent Type of accid	ent (motor vehicle, hockey, etc.)				
YYYY-MM-DD								
If it was a motor vehicle accident, were you the driver?								
How did the accident happen?								
C. DECLARATION								
I declare that all the information given above is complete and true.								
Signature of policyholder Date								





Fees charged for this statement are to be paid by the claimant.

Last name	N ABOUT TE	IE INJURI	RED PERSON – SECTION TO BE COMPLETED BY THE INSURED First name				D	Date of birth		
B. GENERAL IN	FORMATION									
Date of accident		Y Y Y Y - N	1 M - D D			Date of the inju	ury's diagnosis		YYYY-MI	/I - D D
At the time of the a Medication?	Yes	No	under the		cotics?	Yes No		Alcohol	? Yes	No
If so, please provid		esults.								
Diagnosis of an inj	ury									
Fracture or rupture	Specify the b	oone or car	nal in que	stion (attach	a copy of the)	K-ray report)				
	Date		Description of amputation or of loss of use						Is the loss:	
Dismemberment YYYY-MM-D									Total? Permanent?	
or loss of use Level of ampu		outation or	on or percentage of loss of use						Yes No	Yes No
Disability	Date	Y - M M - D	Description							
•	To the best of	of my know	ledge, thi	s patient wa	s totally disa	bled from: YY	Y Y - M M - D D	to:	YYYY-MM	- D D
Date			Field of vision in each eye:			Corrected visual a	Corrected visual acuity in each eye:		the loss of sight total and permanent?	
Loss of sight	Right ey		e Left eye R		Right eye L	tight eye Left eye		eye s	Left eye	
Was the accident t	he cause of:	the injury	?		the amputa	ation or loss	disability?		the loss	s of sight?
If not, explain:		Yes [No		Yes] No	Yes No		Yes	No No
Other attending ph	nveiciane									
Other attending physicians Name					Address					Date (YYYY-MM-DD)
Hospital or other in		re care wa	s rendere	d						Ditaria
	Name					Address				Date (YYYY-MM-DD)
C. IDENTIFICAT Name and address			PRINT)							
Specialty							Permit N	o		
Signature of phy	sician						Date			

D. 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:

- 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, LLC, insurance and reinsurance companies, personal information brokers, investigation firms, the contract holder, my employer or my former employers;
- 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;
- 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;
- to disclose to my personal physician any medical information about me that was obtained during the evaluation of my file;
- to disclose to other insurers or reinsurers any information about me that is relevant to determining my eligibility for insurance or for benefits;
- to provide a brief report on my personal information, including my health information, to MIB, LLC.

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.

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Signature of the policyholder	Date
Signature of the insured who is not a policyholder (in the case of a minor, the signature of the father, mother or tutor)	Date