Desjardins Insurance
Life • Health • Retirement

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

Claim for benefits following an accident

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.
2. Have the physician's statement completed and signed.
3. Provide proof of payment for any additional expenses provided for under the contract.

Contract number

A. IDENTIFICATION OF POLICYHOLDER

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

Insurer's name _____

Policy No. _____

Your spouse ☐ Yes ☐ No

Insurer's name _____

Policy No. _____

Spouse's name (if applicable) _____

B. POLICYHOLDER'S STATEMENT

Last name of the injured	First name	Date of birth YYYY-MM-DD	Sex ☐ F ☐ M

Nature of injury

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 YYYY-MM-DD	Name of hospital		
Date of accident YYYY-MM-DD	Time of accident :	Place of accident	Type of accident (motor vehicle, hockey, etc.)

If it was a motor vehicle accident, were you the driver? ☐ Yes ☐ No

How did the accident happen?

C. DECLARATION

I declare that all the information given above is complete and true.

Signature of policyholder _____ **Date** _____

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Declaration of the attending physician

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

A. INFORMATION ABOUT THE INJURED PERSON – SECTION TO BE COMPLETED BY THE INSURED

Last name	First name	Date of birth

B. GENERAL INFORMATION

Date of accident YYYY-MM-DD	Date of the injury's diagnosis YYYY-MM-DD

At the time of the accident, was the insured under the effect of:

Medication? ☐ Yes ☐ No Narcotics? ☐ Yes ☐ No Alcohol? ☐ Yes ☐ No

If so, please provide us the test results.

Diagnosis of an injury

Fracture or rupture	Specify the bone or canal in question (attach a copy of the X-ray report)		
Dismemberment or loss of use	Date YYYY-MM-DD	Description of amputation or of loss of use	Is the loss: Total? ☐ Yes ☐ No Permanent? ☐ Yes ☐ No
	Level of amputation or percentage of loss of use		
Disability	Date YYYY-MM-DD	Description	
	To the best of my knowledge, this patient was totally disabled from: YYYY-MM-DD to: YYYY-MM-DD		

Loss of sight	Date YYYY-MM-DD	Field of vision in each eye: Right eye _____ Left eye _____	Corrected visual acuity in each eye: Right eye _____ Left eye _____	Is the loss of sight total and permanent? Right eye ☐ Yes ☐ No Left eye ☐ Yes ☐ No

Was the accident the cause of:	the injury?	the amputation or loss of use?	disability?	the loss of sight?
	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

If not, explain:

_____

_____

Other attending physicians

Name	Address	Date (YYYY-MM-DD)

Hospital or other institutions where care was rendered

Name	Address	Date (YYYY-MM-DD)

C. IDENTIFICATION OF PHYSICIAN

Name and address of physician (PLEASE PRINT)

_____

Specialty _____ Permit No. _____

Signature of physician _____ **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.

Signature of the policyholder **Date**

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

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