Desjardins Insurance
Life • Health • Retirement

200, rue des Commandeurs
Lévis (Québec) G6V 6R2
1-800-278-0669

Critical Illness Claim Form
Insured's Statement

Directives

The diseases for which the insured is covered are stated in the booklet or in the contract; please refer to it.

This statement must be completed by the insured. Should the insured be unable to do so, the form can be completed by the insured's legal representative. Please have form 17026A filled in by the attending physician.

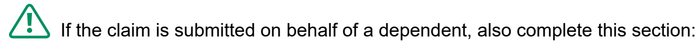
A. Insured's identification

Insured's usual last name	Last name at birth	First name	Date of birth (YYYY-MM-DD)

Address – No., street, apt.	City	Province	Postal code

10-digit phone number (home)	10-digit phone number (work) Extension

Name of policyowner or first insured	Contract No.	OFFICE USE ONLY Representative no.	F.C. No. or Centre No.


If the claim is submitted on behalf of a dependent, also complete this section:

Last name of dependent	First name	Date of birth (YYYY-MM-DD)

Relationship to insured

Address – No., street, apt. Check if same as insured ☐	City	Province	Postal code

10-digit phone number (home)	10-digit phone number (work) Extension

B. Information concerning the person suffering from the critical illness

1. Nature of illness

2. a) When did symptoms of this illness first apprear? (YYYY-MM-DD)	b) When did this person first consult a physician for this illness? (YYYY-MM-DD)	c) When was this person first informed of the illness? (YYYY-MM-DD)

3. a) Name and address of this person's family physician	b) Since when? (YYYY-MM-DD)

c) Name and address of physicians consulted for this illness

d) Name and address of hospitals where this person was treated for this illness

4. Has this person consulted a physician or a health care professional or been hospitalized for one or more medical reasons during the 2 years preceding the current illness? If **yes**, complete the table: ☐ Yes ☐ No

Name of treating physicians or health care professionals	Type of illness or injury	Dates of consultations	Name of hospitals where treatment occurred	Hospitalization periods

5. Were any prescribed medications taken during the 2 years prior to the current illness? If **yes**, complete the table: ☐ Yes ☐ No

Illnesses	Name of medication	Periods (YYYY-MM-DD)	
		From	To
		From	To
		From	To

B. Information concerning the person suffering from the critical illness

6. Does this person smoke cigarettes, cigarillos, cigars, a pipe, or does she use any other form of tobacco or tobacco substitute such as gum or a nicotine patch? ☐ Yes ☐ No

7. Did she ever use tobacco in any form whatsoever? ☐ Yes ☐ No If **yes**, when did she stop? (YYYY-MM-DD) :

8. Is there a history of this disease or a similar illness among this person's immediate family members (father, mother, brother, sister)? ☐ Yes ☐ No

Name of the family member	Relationship	Illnesses	Age at onset of illness	Age if still living	Age at death

C. Declaration

I hereby certify that the above answers are complete and true.

X ______________________________ ______________________________
Signature of the person suffering from the critical illness Date

If the form was completed by the insured's legal representative:

X ______________________________ ______________________________
Your signature Your name in block letters

______________________________ ______________________________
Your relationship to insured 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: (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, LLC, 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, 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.

X ______________________________ ______________________________
Signature of the person suffering from the critical illness (14 years old or older) Date
OR The legal representative

X ______________________________ ______________________________
AND Signature of father, mother or guardian if this person is under the age of majority Date

E. Personal information management

Desjardins Insurance handles the personal information it has on you in a confidential manner. Desjardins Insurance keeps this information on file so that you can benefit from the financial services (insurance, annuities, credit, etc.) it offers. This information is consulted solely by Desjardins Insurance 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 Insurance, 200, rue des Commandeurs, Lévis, Québec, G6V 6R2. Desjardins Insurance can send promotional information or offer new products to individuals whose names appear on its client list. Desjardins Insurance may also give its client list to another component of the Desjardins Group for the same purposes. If you do not want to receive such offers, you may have your name removed from the list by sending a written request to the Privacy Officer at Desjardins Insurance.