Desjardins Insurance
LIFE • HEALTH • RETIREMENT

C. P. 3950
Lévis (Québec) G6V 8C6

GROUP INSURANCE - HEALTH CLAIMS

CLAIM - CONVALESCENT CARE

A - GENERAL INFORMATION - TO BE COMPLETED BY THE MEMBER.

Last name and first name of member	Sex ☐M ☐F	Date of birth YYYY MM DD	Policy or group or contract No.

Address	No., street, apartment			
	City	Province	Postal code	Certificate No.

Name of the person for whom expenses were incurred	Relationship to member	Date of birth YYYY MM DD

Name of group or policyholder or employer	**Signature of administrator (if required)**	**Date** YYYY MM DD

1. Type of event (check the corresponding event(s)) ☐ Hospitalization ☐ Surgery — Date of event YYYY MM DD
2. Describe the circumstances that led to the hospitalization, surgery or accident:

3. Are the claimed benefits covered under another insurance contract? ☐ Yes ☐ No

   If yes: Name of insurer: _____ Contract No.: _____

4. Was Sigma Assistel contacted before services were received? ☐ Yes ☐ No If yes, file No.: _____

IMPORTANT: IF YOUR RETURN TO WORK IS ANTICIPATED, PLEASE ADVISE THE INSURER ON THE RETURN DATE.

B - PERSONAL INFORMATION MANAGEMENT

Desjardins Financial Security Life Assurance Company, hereinafter Desjardins Insurance, handles the personal information it has on you in a confidential manner. Desjardins Insurance keeps this information on file so that you may benefit from group insurance services offered by the Company. This information is consulted solely by Desjardins Insurance employees who need to do so in the course of their work. Desjardins Insurance may compile anonymized personal information for statistical and informational purposes. Desjardins Insurance may also communicate with plan members to provide them with optimal health management. 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 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 Desjardins Insurance.

C - 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 Insurance 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 healthcare 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.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: _____

D - CONVALESCENCE PERIOD - TO BE COMPLETED BY THE ATTENDING PHYSICIAN WHO PRESCRIBED THE CONVALESCENCE.

1. Diagnosis: _____
2. Treatment or type of surgery: _____
3. Hospitalization: Admission date: (YYYY MM DD) _____ Discharge date: (YYYY MM DD) _____

   Name of hospital: _____
4. Check the loss of autonomy criteria justifying a period of convalescence:
   - ☐ Eating - The insured person needs assistance in preparing meals or feeding himself.
   - ☐ Moving - The insured person needs assistance in getting out of a bed or a chair, lying down or sitting.
   - ☐ Dressing - The insured person needs assistance in putting on or taking off his clothes and his orthopedic prosthesis.
   - ☐ Taking care of basic hygiene needs - The insured person needs assistance in washing, getting in or out of the bathtub or shower or using the toilet.
5. Period of prescribed convalescence: period during which the insured person must necessarily present one or more loss of autonomy criteria listed above:

   From (YYYY MM DD) _____ To (YYYY MM DD) _____ Number of days: _____
6. Did you recommend home nursing care? ☐ Yes ☐ No If yes, for which type of services? _____
7. Did the insured person previously consult you or another professional for the condition requiring hospitalization or sugery before (YYYY MM DD) _____? ☐ Yes ☐ No

   If yes, please provide the following information:

Name of attending physician	Date of visits (YYYY MM DD)	Diagnosis	Treatments

8. Was the convalescence prescribed following a delivery? ☐ Yes ☐ No

   If yes, was the insured person hospitalized at your recommendation for more than seven (7) days **after** delivery due to complications?

   ☐ Yes ☐ No If yes, please indicate the:

   a) Number of days in hospital (after delevery): _____ days

   b) Details of complications : _____

Name and address of the attending physician (PLEASE PRINT)

_____ **Licence No.:** _____

_____

_____ **Telephone No.:** ( ) -

Signature of attending physician: **Date:**

For all benefits claimed: 1. You must submit the original receipt which includes all details of services rendered.
2. When the space available is not sufficient, you may attach a separate sheet which you must date and sign.

E - DOMESTIC ASSISTANCE SERVICES - TO BE COMPLETED BY THE INSURED PERSON OR BY THE MEMBER.

Date of services YYYY MM DD	Details of services	Number of days	Fees per day
			$
			$
			$

Name of provider: _____

Address: _____

_____ Telephone No.: ( ) -

Relationship to member: ☐ FRIEND ☐ FAMILY MEMBER ☐ OTHER, please specify: _____

F - HOME NURSING CARE - TO BE COMPLETED BY THE INSURED PERSON OR BY THE MEMBER.

What services were provided?	Date of services YYYY MM DD	Hourly rate	Number of hours	Amount
				$
				$
				$

Name of the nurse: _____

Address: _____

Licence No.: _____ Telephone No.: ( ) -

Relationship to member: ☐ FRIEND ☐ FAMILY MEMBER ☐ OTHER, please specify: _____

G - STAY IN A CONVALESCENT FACILITY - TO BE COMPLETED BY THE INSURED PERSON, BY THE MEMBER OR BY THE CONVALESCENT FACILITY.

Name and address of the convalescent facility

_____

_____

_____

Duration of stay: YYYY MM DD YYYY MM DD

From: _____ To: _____ Amount: $ _____

H - CUSTODIAL SERVICES - TO BE COMPLETED BY THE INSURED PERSON OR BY THE MEMBER.

Date of services YYYY MM DD	Name of child	Date of birth YYYY MM DD	Amount claimed	Amount normally paid for child care
			$	$
			$	$
			$	$

Name of baby-sitter: _____

Address: _____

_____ Telephone No.: ( ) -

Relationship to member: ☐ FRIEND ☐ FAMILY MEMBER ☐ OTHER, please specify: _____

I - TRANSPORTATION EXPENSES - TO BE COMPLETED BY THE INSURED PERSON OR BY THE MEMBER AND SIGNED BY EACH PHYSICIAN OR HEALTH PROFESSIONAL CONSULTED.

Only eligible following surgery or hospitalization.

Dates YYYY / MM / DD	Round-trip transportation used	Care provided		Name, address and licence No. of physician or professional
	$ Taxi			
	km $ Private car / Parking		**Signature of physician or professional**	
	$ Public transit			
YYYY / MM / DD				
	$ Taxi			
	km $ Private car / Parking		**Signature of physician or professional**	
	$ Public transit			
YYYY / MM / DD				
	$ Taxi			
	km $ Private car / Parking		**Signature of physician or professional**	
	$ Public transit			