Desjardins Insurance
LIFE • HEALTH • RETIREMENT

200, rue des Commandeurs
Lévis (Québec) G6V 6R2

GROUP INSURANCE

# CRITICAL ILLNESS CLAIM FORM
## INSURED'S STATEMENT

**We cannot settle this claim unless all questions are answered adequately.**

- 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 provide the Critical illness claim form – Attending physician's statement (form no. 17026A) and the Claim – Employer's statement (form no. 12123E) along with the required documents.

**To contact us: 1-877-938-8191**

## A. Information about the insured

| Last name | First name | Date of birth |
|---|---|---|
| | | YYYY-MM-DD |

| Address - No., street | City | Province | Postal Code |
|---|---|---|---|
| | | | |

| Telephone nos. | Home: AREA CODE + NUMBER | Work: AREA CODE + NUMBER | Ext.: |
|---|---|---|---|
| | | | |

| Employer of insured | Contract/group no. | Account/division no. | Identification no. of the insured |
|---|---|---|---|
| | | | |

**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 Check if same as insured: ☐ | City | Province | Postal Code |
|---|---|---|---|
| | | | |

| Telephone nos. | Home: AREA CODE + NUMBER | Work: AREA CODE + NUMBER | Ext.: |
|---|---|---|---|
| | | | |





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## B. General information

1. Diagnosis

2. When did symptoms of this illness first appear? YYYY-MM-DD

3. When did you first consult a physician for this illness? YYYY-MM-DD

4. Do you have a family doctor? ☐ Yes ☐ No

Doctor's name: _____ Since when? _____

5. In the 2 years preceding your date of diagnosis, did you consult a physician or healthcare professional or were you hospitalized for any medical reasons? ☐ Yes ☐ No If yes, please complete the table:

| Name of physicians or professionals consulted | Medical reasons | Dates of consultation | Name of hospitals where you were treated | Hospitalization periods |
|---|---|---|---|---|
| | | YYYY-MM-DD | | from: YYYY-MM-DD<br>to: YYYY-MM-DD |
| | | YYYY-MM-DD | | from: YYYY-MM-DD<br>to: YYYY-MM-DD |

6. In the 2 years preceding your date of diagnosis, did you take any medication? ☐ Yes ☐ No
If yes, please complete the table:

| Medical reasons | Name of medication | Periods |
|---|---|---|
| | | from: YYYY-MM-DD<br>to: YYYY-MM-DD |
| | | from: YYYY-MM-DD<br>to: YYYY-MM-DD |

7. Do you smoke cigarettes, cigarillos, cigars, a pipe, or do you use any other form of tobacco or tobacco substitute such as gum or a nicotine patch? ☐ Yes ☐ No

8. Did you ever use tobacco in any form whatsoever? ☐ Yes ☐ No If yes, when did you stop? YYYY-MM-DD

9. Is there a history of this disease or a similar illness among your immediate family members (spouse, son, daughter, father, mother, brother, sister, grandfather, grandmother, uncle, aunt)? ☐ Yes ☐ No If yes, complete the table:

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

**Declaration –** I declare that the information provided above is complete and true.

**Signature of insured (or representative)** _____ **Date** _____

**PERSONAL INFORMATION MANAGEMENT**

Desjardins Financial Security Life Assurance Company (DFS) handles the personal information it has on you in a confidential manner. DFS 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 DFS 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 Financial Security Life Assurance Company, 200, rue des Commandeurs, Lévis, Québec, G6V 6R2. DFS can send promotional information or offer new products to individuals whose names appear on its client list. DFS may use the client list to offer its clients an insurance product following the termination of their group insurance. 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 DFS.

## C. Authorization to collect and communicate personal information

For the sole purpose of determining insurability, managing files and processing claims, I authorize Desjardins Financial Security Life Assurance Company (DFS) 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 of my personal 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.

**Signature of the insured**
**OR the legal representative X** **Date**

**AND signature of father, mother or guardian if this person is under the age of majority X**