Desjardins Financial Security™

P.O. Box 4358, STN A
Toronto ON M5W 3M3

CLAIM FOR HEALTH CARE BENEFITS

TO EXPEDITE PROCESSING OF YOUR CLAIM, PLEASE ANSWER ALL QUESTIONS.
(Missing or inaccurate information may result in handling delays, and the form may be returned to you for correction.)

A

Policy or Group or Contract No.	Certificate No.		
Member's Last Name and First Name		Sex ☐ M ☐ F	Date of Birth YYYY-MM-DD
Number, Street, Apartment			
City, Province		Postal Code	
Name of Group or Policyholder or Employer			

IF GROUP IS SELF-ADMINISTERED, the administrator must complete this section before the member fills out the form

In force	Individual	YYYY-MM-DD
	Family	YYYY-MM-DD
	Other, specify	YYYY-MM-DD
Terminated		YYYY-MM-DD

Administrator's signature

Date

B

Is the claim the result of:

- **a work injury?** ☐ **Yes** ☐ **No**
- **a motor vehicle accident?** ☐ **Yes** ☐ **No**

If yes:
- Please note that the claim must first be submitted under your provincial workers' compensation plan or automobile insurance plan (if applicable in your province) before being submitted to your group plan.
- Name of injured person ____________________ Date of accident YYYY-MM-DD

C

COORDINATION OF BENEFITS - This section MUST BE COMPLETED if claiming for a spouse or child.
The coordination of benefits may entitle you to a reimbursement of up to 100% of your expenses.

HOW TO SUBMIT A CLAIM WHEN THERE ARE TWO INSURERS

1. A spouse must first submit their claim to their own insurer and provide Desjardins Financial Security Life Assurance Company with the explanation of benefits paid by their plan including copies of the receipts.
2. Claims for dependent children must first be submitted under the plan of the parent whose birthday (month and day) comes first in the calendar year.

Is your spouse insured under another insurance contract that provides benefits for:

- **drugs:** ☐ **Yes** ☐ **No**
- **paramedical services:** ☐ **Yes** ☐ **No**
- **vision care:** ☐ **Yes** ☐ **No**

If yes, is the coverage: ☐ individual ☐ family

EFFECTIVE DATE YYYY-MM-DD
TERMINATION DATE YYYY-MM-DD

Full name of spouse ____________________
Date of birth YYYY-MM-DD

Name of insurer ____________________ Policy No. ____________________ Certificate No. ____________________

D

PATIENT INFORMATION for the period in which expenses were incurred (use one line per patient). I confirm that the persons designated below fit the definition of spouse and dependent child as specified in the contract under which this claim has been submitted.

CHILDREN AGED 18 OR 21 OR OLDER (the specific age depends on the plan provisions)

Last Name	First Name	Participant	Spouse	Child	Sex	Date of Birth	Full-time Student	Name of Educational Institution Attended
		☐	☐	☐	☐ M ☐ F	YYYY-MM-DD	☐ Yes ☐ No From YYYY-MM-DD To YYYY-MM-DD	
		☐	☐	☐	☐ M ☐ F	YYYY-MM-DD	☐ Yes ☐ No From YYYY-MM-DD To YYYY-MM-DD	
		☐	☐	☐	☐ M ☐ F	YYYY-MM-DD	☐ Yes ☐ No From YYYY-MM-DD To YYYY-MM-DD	
		☐	☐	☐	☐ M ☐ F	YYYY-MM-DD	☐ Yes ☐ No From YYYY-MM-DD To YYYY-MM-DD	

E

DIRECT DEPOSIT - This section need only be completed if this is your initial request for direct deposit or to make a change to your existing account information. Include specimen cheque marked "VOID" for first requests or changes only.

Name and address of the financial institution	Transit number	Account number

F

HEALTH SPENDING ACCOUNT - Complete this section if you have this coverage.

Should the portion of expenses not covered under your contract be applied against your health spending account? ☐ Yes ☐ No

If you or your dependent children are covered under your spouse's insurance plan, would you like the portion of expenses not paid under the basic plan to be automatically processed through the health spending account instead of submitting them for coordination to your spouse's insurer? ☐ Yes ☐ No

Would you like the expenses for items requiring a medical recommendation to be paid automatically into the health spending account, if this recommendation is not appended to your claim? ☐ Yes ☐ No

IMPORTANT INFORMATION

- **Send original receipts only (copies will not be accepted). Please keep copies for your records, the originals will not be returned. The explanation of benefits you will receive from us, along with copies of your receipts, are acceptable proof of expense for income tax purposes and coordination of benefits with other carriers.**
- **Claims MUST BE submitted no later than one year after expenses are incurred.**

G DRUG EXPENSES

- Attach your prescription drug receipts to this form.
- All receipts must contain the drug identification number (DIN) and the name of the drug.

H MEDICAL/PARAMEDICAL EXPENSES (e.g.: chiropractor, massage therapist, physiotherapist)

If a medical recommendation is required under the terms of your policy, please include it.

Please attach an itemized statement or a receipt stating:

- patient's name
- practitioner's name
- practitioner's licence or registration number
- type of practitioner
- length of visit
- date(s) of visit(s)
- charge for each treatment
- date at which the patient reached the maximum payable by province's health plan (if applicable)

If for psychotherapy, please indicate the type: ☐ individual ☐ family ☐ group ☐ marriage

I EQUIPMENT AND APPLIANCE EXPENSES

If required under the terms of your policy (usually required under all policies, but please consult your booklet if you are unsure) provide the attending physician's written recommendation for the equipment or appliance prescribed, including the diagnosis, and a copy of the provincial-plan payment summary, if applicable.

Indicate the period of time the equipment will be required: from: _____ to: _____

J VISION CARE EXPENSES

Please attach an itemized receipt stating:

- patient's name
- cost of frames
- cost of lenses
- cost of contact lenses
- cost of tinting
- cost of eye exam
- date of eye exam
- date dispensed

Are you claiming expenses incurred to replace a pair of glasses? ☐ Yes ☐ No

Was a new eye exam required to replace the glasses? ☐ Yes ☐ No If yes, enclose a true copy of the old and new prescriptions (if required by your contract).

K

To the best of my knowledge, all the information I have provided on the claim form is accurate and complete.

Signature of member: _____ Date: _____

Telephone Nos: Home: Area code + Number Office: Area code + Number Extension:

Print the form