Desjardins Financial Security™

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

CLAIM FOR HEALTH CARE BENEFITS

TO ACCELERATE THE PROCESS WHEN SUBMITTING A CLAIM, PLEASE ANSWER ALL THE QUESTIONS.
(This claim will be delayed and may be returned to you if there is missing or incorrect information)

A

Policy or Group or Contract No.

Identification or Certificate No. or S.I.N.

Member's Last Name First Name

Sex ☐ M ☐ F

Date of Birth YY 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 YY MM DD; Family YY MM DD; Other, specify YY MM DD

Terminated YY MM DD

Administrator's signature

Date

B

Are the claims 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** YY MM DD

C

COORDINATION OF BENEFITS (this section MUST BE COMPLETED if claiming for a spouse or child)

1. A spouse must first submit to his or her own insurer and provide Desjardins Financial Security Life Assurance Company with the details of the benefits paid by his or her plan (i.e. the Explanation of Benefit from the spouse's insurer 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: YY MM DD

TERMINATION DATE: YY MM DD

Full name of spouse: _____

Date of birth: YY MM DD

Name of insurer _____ Policy No. _____ Identification or 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	YY MM DD	☐ Yes ☐ No From YY MM DD To YY MM DD	
		☐	☐	☐	M F	YY MM DD	☐ Yes ☐ No From YY MM DD To YY MM DD	
		☐	☐	☐	M F	YY MM DD	☐ Yes ☐ No From YY MM DD To YY MM DD	
		☐	☐	☐	M F	YY MM DD	☐ Yes ☐ No From YY MM DD To YY 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 (you may wish to coordinate benefits with your spouse's plan before using your health spending account)

Should the portion of expenses not covered under your contract be applied against your health spending account? ☐ 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 (D.I.N.) and the name of the drug.

H PRACTITIONER'S/PARAMEDICAL EXPENSES (e.g. chiropractor, massage therapist, physiotherapist)

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

For practitioner's/paramedical expenses please attach an itemized statement and/or receipt stating:

- patient name
- name of practitioner
- license and/or registration number of the practitioner
- type of practitioner
- length of visit
- date of service
- charge for 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 physician's written recommendation for the equipment or appliance prescribed, including the diagnosis, and a copy of the provincial plan statement of payment, if applicable.

Indicate the period of time the equipment will be required: From: _____ To: _____

J VISION CARE EXPENSES

Please enclose an itemized receipt indicating:

- 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: ( ) Office: ( )