Desjardins Insurance
Life • Health • Retirement

Group Insurance - Health Claims

CLAIM FOR DENTAL CARE EXPENSES

A DENTIST INFORMATION

Last name and first name | Member number | Telephone number

Address - No., street, suite | City | Province | Postal code

B CLAIM INFORMATION

IMPORTANT: If the claim is for dental treatment due to an accident, a crown, veneer application, inlay or denture, please refer to sections J and K.
If the treatment requires more than one session, the date of treatment must be the date on which the treatment terminates or the insertion date.

Last name and first name of the patient | Date of birth YYYY MM DD | Relationship to the member ☐ Spouse ☐ Daughter ☐ Son

Treatment date YY MM DD	Tooth no.	Procedure code	Tooth surface	Laboratory expenses	Dentist's fees	Total charge

Total fee claimed:

Diagnosis - This section is reserved for the dentist:

THIS IS AN ACCURATE STATEMENT OF SERVICES PERFORMED AND FEES CHARGED.

Signature of dentist: Date:

C ASSIGNMENT OF BENEFITS

I assign benefits payable from this claim to the above named dentist and authorize Desjardins Financial Security Life Assurance Company, hereinafter Desjardins Insurance, to pay the dentist directly.

Signature of member: **Date:**

D MEMBER INFORMATION **To be completed by the member.**

Name of group or policyholder or employer | Policy or group or contract no. | Certificate no.

LE COMITE PARITAIRE D'INSTALLATION D'EQUIPEMENTS PETROLIERS DU QUEBEC | E012

Member's last name and first name | Sex ☐M ☐F | Date of birth YYYY MM DD

Address - No., street, apartment | City | Province | Postal code

Complete only if you are claiming expenses incurred for your dependent children aged 18 and over or 21 and over (depending on the contract). Remember to include the information for the period in which the expenses were incurred for your child. If your child has a functional impairment, please provide us with a medical certificate confirming your child's disability.

☐ Has a functional impairment

☐ Full-time student - Name of educational institution attended: Period: From YYYY MM DD To YYYY MM DD

E COORDINATION OF BENEFITS **To be completed by the member.**

Last name and first name of person who has the other insurance plan | Sex ☐M ☐F | Date of birth YYYY MM DD

Name of insurer
☐ Other ☐ Desjardins Insurance - Contract no.: Certificate no.:

Period of coverage YYYY MM DD To YYYY MM DD
From

Type of dental coverage: ☐ Individual ☐ Couple ☐ Single-parent ☐ Family

Last name and first name of the dependents covered under this other insurance plan

F HEALTH SPENDING ACCOUNT **If you have this benefit, check the option you would like.**

I confirm that I am eligible for a reimbursement of the indicated expenses under my Health Spending Account.
I recognize that I am responsible for paying any taxes that may result from the reimbursement of these expenses and that, for tax or administrative purposes, my plan administrator may have access to a statement of expenses for which I claimed a reimbursement under my Health Spending Account.

☐ I do not wish to use my Health Spending Account.

☐ **Ineligible expenses** - I wish to use my Health Spending Account to cover the expenses that are not reimbursed under my group insurance plan.

☐ **Spouse's family coverage** - I wish to use my Health Spending Account for myself and my dependent children to cover the expenses that are not reimbursed under my group insurance plan. I will not submit a claim to my spouse's insurer (coordination of benefits).

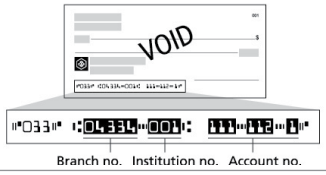
Desjardins Insurance refers to Desjardins Financial Security Life Assurance Company.

G DIRECT DEPOSIT SERVICE

Attach a void cheque or provide your bank information below to sign up for direct deposit.

Transit/branch no.	Institution no.	Account no.

Your email address (mandatory)



Once registered, your reimbursements for health care services will be deposited into this bank account. A notification email will be sent once your claims have been processed, and the explanation of benefits will be posted online rather than mailed. You must be registered on the secure site to consult your explanation of benefits. To register, go to desjardinslifeinsurance.com/planmember.

Desjardins Insurance, is not responsible for the accuracy of the banking information you enter and for verifying that the due amounts are deposited into your account.

H 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 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.

I DECLARATION AND AUTHORIZATION FOR THE COLLECTION AND COMMUNICATION OF PERSONAL INFORMATION

I understand that I am responsible for the total cost of the treatment 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 health care 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 the member: **Date:**

Telephone nos: Home: Office: Extension:

J DENTAL TREATMENT DUE TO AN ACCIDENT

TO BE COMPLETED BY THE MEMBER

Date of the accident: YYYY MM DD Location of the accident:

How did the accident occur?

If the claim is the result of a work injury or a motor vehicule accident, please note that the claim must first be submitted to your provincial automobile insurance (if applicable in your province) or occupational health and safety plan before being forwarded to your insurer.

TO BE COMPLETED BY THE DENTIST

Is it an accidental injury to a healthy and natural tooth? ☐ Yes ☐ No

Diagnosis and clinical description prior to the accident:

Preoperative X-rays are required for the study of dental treatment due to an accident. They will be returned to the attending dentist as soon as possible.

K CLAIM FOR A CROWN, VENEER, INLAY/ONLAY, FIXED BRIDGE OR DENTURE

- **For crown, veneer or inlay/onlay:** Please submit pre-treatment x-rays. If replacement, please indicate the age of the existing appliance.
- **For fixed bridge:** Please submit pre-treatment x-rays with clear views of both sides of the arch(s). If replacement, please indicate the age and type of the existing prosthesis. If initial, please indicate the extraction date of the missing teeth.
- **For denture:** If replacement, please indicate the age and type of the existing prosthesis. If initial, please indicate the extraction date of the missing teeth.

Please include a copy of the commercial lab bill with your claim.

Please sign section I and send to: Desjardins Insurance, C. P. 3950, Lévis (Québec) G6V 8C6

PRINT NEW REQUEST