Desjardins Insurance
LIFE • HEALTH • RETIREMENT

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

GROUP INSURANCE

ACCIDENTAL DISMEMBERMENT OR LOSS OF SIGHT CLAIM FORM

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

- Please complete sections which need answers and provide the Claim – Employer's Statement (form no. 12123E).

To contact us: 1-877-938-8191

A. Information about the insured

1- Last name	2 - First name		
3 - Address - No., Street	City	Province	Postal Code
4 - Telephone nos. Home: Area code + Number	Work: Area code + Number	Ext.	
5 - Employer of principal insured	Contract/group no.	Account/division no.	Identification no. of the insured
6 - Last name of injured person (If other than the insured)	7 - First name		
8 - Address - No., Street	City	Province	Postal Code
9 - Telephone nos. Home: Area code + Number	Work: Area code + Number	Ext.	

B. Insured child - If aged between 18 and 25 inclusively or between 21 and 25 inclusively (according to contract)

Is he/she a full-time student? ☐ Yes ☐ No If Yes, provide name and address of educational institution:

C. Details about the accident

1 - Date of accident: YYYY- MM - DD

2 - Was the injured person: ☐ the driver ☐ a passenger

3 - Is it:
☐ a work-related accident ☐ an occupational illness
☐ a motor vehicle accident ☐ other, please specify:

4 - Brief description of accident

D. Description of injuries

1 - Brief description of injuries

2 - Did the injured person undergo surgery? ☐ Yes ☐ No If Yes, please specify:

Type of surgery: Date of surgery: YYYY - MM - DD

E. Declaration of insured

DIRECT DEPOSIT - If you want your benefits to be deposited directly into your account, complete this section and enclose a void cheque

Identification no. (transit) | Account no.

DECLARATION – I declare that the information provided above is complete and true. I acknowledge that I have read the notice on the reverse of this form regarding the personal information management.

Signature of insured _____ **Date** YYYY - MM - DD

F. 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 injured person (14 years old or older) _____ **Date** YYYY - MM - DD

AND Signature of father, mother or guardian if this person is under the age of majority

Fees charged for this statement are to be paid by the insured.

ATTENDING PHYSICIAN'S STATEMENT

ACCIDENTAL DISMEMBERMENT OR LOSS OF SIGHT

SECTION TO BE COMPLETED BY INSURED

A. Information about the injured person

1 - Last name	2 - First name	3 - Date of birth YYYY - MM - DD

B. 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.

SECTION TO BE COMPLETED BY PHYSICIAN

C. General information

1 - Date of accident: YYYY - MM - DD

2 - If there is a loss of use, is it total and permanent? ☐ Yes ☐ No

3 - Did the total and permanent loss occur during the 365-day period following the accident? ☐ Yes ☐ No

4 - Is it:
☐ a work-related accident ☐ an occupational illness
☐ a motor vehicle accident ☐ other, please specify:

5 - Description of loss - Please mention the ICD code

6 - If there is a dismemberment or loss of use, specify the level of amputation or % of loss of use

Date YYYY - MM - DD

7 - Loss of sight at last examination dated: YYYY - MM - DD

	Left eye	Right eye
(a) Visual acuity		
(b) Acuity with glasses		
(c) Vision may be fully or partially corrected by:	☐ Glasses ☐ Treatment ☐ Operation ☐ No method	☐ Glasses ☐ Treatment ☐ Operation ☐ No method

8 - Is the loss of use the direct result of the accident and independent of any other cause? ☐ Yes ☐ No

If No, please explain:

_____

_____

_____

_____

9 - At the time of the accident, did the insured take:
medication? ☐ Yes ☐ No drugs? ☐ Yes ☐ No alcohol? ☐ Yes ☐ No
If so, please provide us tests results.

10 - Other attending physicians

Name _____ Address _____ Date _____

Name _____ Address _____ Date _____

Name _____ Address _____ Date _____

11 - Hospitals or other institutions where care were rendered

Name _____ Address _____ Date _____

Name _____ Address _____ Date _____

Name _____ Address _____ Date _____

12 - Comments

D. Identification of physician

Name, address: _____ Telephone no: Area code + Number

License no: _____ Fax no: Area code + Number

☐ General practitioner ☐ Specialist Specify: _____

Signature: _____ Date: YYYY - MM - DD

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