Desjardins Insurance
LIFE • HEALTH • RETIREMENT

C. P. 3950
Lévis (Québec) G6V 8C6
Fax: 418-838-2134
1-877-838-2134

GROUP INSURANCE - HEALTH CLAIMS

REQUEST FOR REIMBURSEMENT OF BRAND NAME MEDICATIONS

IMPORTANT INFORMATION

- Any charges for the completion of this form are the member's responsibility.
- The brand name medication for which you are applying for an exception is currently covered up to the lowest cost generic equivalent available on the market. If this exception is approved, the medication will be covered at the price provided for the brand name medication.
- Please complete sections A and B and have your physician complete sections C and D. The exception will only be approved if the physician provides an acceptable medical reason to support why the patient is unable to take the lowest cost generic equivalent available on the market. This request will be assessed based on the medical information provided and may be reviewed by our physician or pharmacist.

A - PATIENT'S IDENTIFICATION - To be completed by the member.

Name of policyholder		Group no.	Certificate no.
Last name and first name of member		Sex ☐ M ☐ F	Date of birth YYYY MM DD
Address - No., street, apt.	City	Province	Postal code
Last name and first name of patient		Sex ☐ M ☐ F	Date of birth YYYY MM DD
Relationship to member		DIN (Drug Identification Number)	

B - DECLARATION AND AUTHORIZATION FOR THE COLLECTION AND COMMUNICATION OF PERSONAL INFORMATION

All the information I have provided on the claim form is accurate and complete. I acknowledge having read the Personal Information Management section at the back of the form. I authorize Desjardins Financial Security Life Assurance Company (DFS), hereinafter 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 healthcare 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 member ______________________ **Date** ______________

Signature of insured dependent aged 16 and over: **Date:**

C - PHYSICIAN'S STATEMENT - To be completed by physician.

1. Drug prescribed (product name, strength, dosage): ______________________
2. What is the patient's diagnosis? ______________________
3. Has the patient tried the generic version of the drug? ☐ Yes ☐ No
4. What is the medical reason for the request? ☐ Contraindication ☐ Adverse reaction ☐ Therapeutic failure
   ☐ Other: ______________________
5. Please explain the medical reason given in question 4 and add any additional information relevant to the request:
   ____

D - PHYSICIAN'S IDENTIFICATION - To be completed by physician.

Last name and first name of physician (PLEASE PRINT)			
Address - No., street, suite	City	Province	Postal code
Telephone no.: ( ) -		Fax no.: ( ) -	
Signature of physician:		**Date:**	

Please send form by fax: 418-838-2134 or 1-877-838-2134
or by mail: Desjardins Insurance, C. P. 3950, Lévis (Québec) G6V 8C6

Desjardins Insurance refers to Desjardins Financial Security Life Assurance Company.

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.