Desjardins Insurance
LIFE • HEALTH • RETIREMENT

C. P. 3950
Lévis (Québec) G6V 8C6
desjardinslifeinsurance.com

GROUP INSURANCE - HEALTH CLAIMS

CLAIM FOR DENTAL CARE EXPENSES

DENTIST INFORMATION

Last name and first name	Member no.	Telephone no. ( ) -
Address - No., street, suite	City	Province / Postal code

CLAIM INFORMATION

IMPORTANT: If the claim is for dental care subsequent to an accident, a crown, veneer application, inlay or denture, please see the reverse side. 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:

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:**

MEMBER INFORMATION

To be completed by the member. To expedite processing of your claim, please answer all questions.

Name of group or policyholder or employer	Policy or group or contract no.	Certificate no.
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 policy). 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.

Full-time student or has functional impairment:	Name of educational institution attended
☐ Funct. imp. ☐ Full time stud.: From YYYY MM DD To YYYY MM DD	

COORDINATION OF BENEFITS

To be completed by the member.

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

Name of insurer ☐ Desjardins Insurance ☐ Other	Period of coverage From YYYY MM DD To YYYY MM DD	If the other insurer is Desjardins Insurance: Contract no.: Certificate no.:

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

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

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).

PLEASE COMPLETE THE BACK OF THE FORM.

Desjardins Insurance refers to Desjardins Financial Security Life Assurance Company.

DIRECT DEPOSIT SERVICE

By opting for direct deposit, you will get your payments faster and they will be deposited directly in your bank account, you will be notified by email once your claims have been processed, and your explanation of benefits will be posted online rather than mailed to you.

To enrol in this service, please attach a VOID cheque to your claim **and** provide your email address (required): _____

For more details on this service, to view your explanation of benefits or to make changes to your personal information, please visit our website at desjardinslifeinsurance.com/planmember.

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.

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:

DENTAL CARE SUBSEQUENT 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 care made necessary as the result of an accident. They will be returned to the attending dentist as soon as possible.

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 send to: Desjardins Insurance, C. P. 3950, Lévis (Québec) G6V 8C6