

TO EXPEDITE PROCESSING OF YOUR CLAIM, PLEASE ANSWER ALL QUESTIONS.

(Missing or inaccurate information may result in handling delays, and the form may be returned to you for correction.)

A	Group No. 141000		Certificate No.		IF GROUP IS SELF-ADMINISTERED, the administrator must complete this section before the member fills out the form		
	Member's Last Name		First Name		Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth YYYY-MM-DD	In force Individual YYYY-MM-DD
	Number, Street, Apartment						Family YYYY-MM-DD
	City, Province		Postal Code				Other, specify YYYY-MM-DD
	Name of Group or Policyholder or Employer Government of Newfoundland and Labrador				Terminated YYYY-MM-DD		Administrator's signature
						Date	

B	<p>Is the claim the result of:</p> <p>• a work injury? <input type="checkbox"/> Yes <input type="checkbox"/> No • a motor vehicle accident? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>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.</p> <p>• Name of injured person _____ Date of accident <input type="text" value="YYYY-MM-DD"/></p>
----------	--

C	<p>COORDINATION OF BENEFITS - This section MUST BE COMPLETED if claiming for a spouse or child.</p> <p>The coordination of benefits may entitle you to a reimbursement of up to 100% of your expenses.</p> <p>HOW TO SUBMIT A CLAIM WHEN THERE ARE TWO INSURERS</p> <ol style="list-style-type: none"> A spouse must first submit their claim to their own insurer and provide Desjardins Financial Security Life Assurance Company with the explanation of benefits paid by their plan including copies of the receipts. 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. <p>Is your spouse insured under another insurance contract that provides benefits for:</p> <p>• drugs: <input type="checkbox"/> Yes <input type="checkbox"/> No • paramedical services: <input type="checkbox"/> Yes <input type="checkbox"/> No • vision care: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, is the coverage: <input type="checkbox"/> individual EFFECTIVE DATE <input type="text" value="YYYY-MM-DD"/> Full name of spouse _____ <input type="checkbox"/> family TERMINATION DATE <input type="text" value="YYYY-MM-DD"/> Date of birth <input type="text" value="YYYY-MM-DD"/></p> <p>Name of insurer _____ Policy No. _____ Certificate No. _____</p>
----------	---

D	PATIENT INFORMATION for the period in which expenses were incurred (use one line per patient).						CHILDREN AGED 21 OR OLDER	
	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.							
	Last Name	First Name	Spouse	Child	Sex	Date of Birth	Full-time Student <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of Educational Institution Attended
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> M <input type="checkbox"/> F	YYYY-MM-DD	From <input type="text" value="YYYY-MM-DD"/> To <input type="text" value="YYYY-MM-DD"/>	
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> M <input type="checkbox"/> F	YYYY-MM-DD	From <input type="text" value="YYYY-MM-DD"/> To <input type="text" value="YYYY-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

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.

F DRUG EXPENSES

- Attach your prescription drug receipts to this form.
- All receipts must contain the drug identification number (DIN) and the name of the drug.

G MEDICAL/PARAMEDICAL EXPENSES (e.g.: chiropractor, massage therapist, physiotherapist)

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

Please attach an itemized statement or a receipt stating:

- | | |
|---|---|
| • patient's name | • length of visit |
| • practitioner's name | • date(s) of visit(s) |
| • practitioner's licence or registration number | • charge for each treatment |
| • type of practitioner | • 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

H 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 attending physician's written recommendation for the equipment or appliance prescribed, including the diagnosis, and a copy of the provincial-plan payment summary, if applicable.

Indicate the period of time the equipment will be required: from: _____ to: _____

I VISION CARE EXPENSES

Please attach an itemized receipt stating:

- | | |
|--------------------------|--------------------|
| • patient's name | • cost of tinting |
| • cost of frames | • cost of eye exam |
| • cost of lenses | • date of eye exam |
| • cost of contact lenses | • 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).

J 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 may benefit from group insurance services offered by the Company. 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.

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

To the best of my knowledge, 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 Financial Security Life Assurance Company, 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 minor children, insofar as applicable to the claim. A photocopy of this authorization is as valid as the original.

Signature of member: _____

Date: _____

Telephone Nos: Home: Area code + Number

Office: Area code + Number

Extension: _____