Desjardins Financial Security®

C.P. 3950
Lévis (Québec) G6V 8C6

FINANCIAL SERVICES INCLUDING INSURANCE, ANNUITIES, CREDIT AND RELATED SERVICES

CLAIM - CONVALESCENT CARE

A - GENERAL INFORMATION - TO BE COMPLETED BY THE MEMBER

Member's First Name and Last Name	Sex ☐ M ☐ F	Date of birth YYYY MM DD	Policy or Group or Contract No.

Address	Number, street, apartment		
	City, Province	Postal code	Certificate No.

Name of the person for whom expenses were incurred	Relationship to member	Date of birth YYYY MM DD

Name of Group or Policyholder or Employer	Signature of administrator (if required)	Date

1. Type of event (check the corresponding event(s)) ☐ Hospitalization ☐ Surgery

Date of event YYYY MM DD

2. Describe the circumstances that led to the hospitalization, surgery or accident:

3. Are the claimed benefits covered under another insurance contract? ☐ Yes ☐ No

   If yes: Name of the insurer: Contract No.:

4. Was Sigma Assistel contacted before services were received? ☐ Yes ☐ No If yes, file No.:

IMPORTANT: IF YOUR RETURN TO WORK IS ANTICIPATED, PLEASE ADVISE THE INSURER ON THE RETURN DATE.

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 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. DFS 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 DFS.

C - 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. 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 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: (Area code + Number) Office: (Area code + Number) Extension:

D - CONVALESCENCE PERIOD - TO BE COMPLETED BY THE ATTENDING PHYSICIAN WHO PRESCRIBED THE CONVALESCENCE

1. Diagnosis:

2. Treatment or type of surgery:

3. Hospitalization: Admission date: (YYYY MM DD) Discharge date: (YYYY MM DD)

   Name of hospital:

4. Check the loss of autonomy criteria justifying a period of convalescence:

   - ☐ Eating - The insured person needs assistance in preparing meals or feeding himself.
   - ☐ Moving - The insured person needs assistance in getting out of a bed or a chair, lying down or sitting.
   - ☐ Dressing - The insured person needs assistance in putting on or taking off his clothes and his orthopedic prosthesis.
   - ☐ Taking care of basic hygiene needs - The insured person needs assistance in washing, getting in or out of the bathtub or shower or using the toilet.

5. Period of prescribed convalescence: period during which the insured person must necessarily present one or more loss of autonomy criteria listed above:

   From (YYYY MM DD) to (YYYY MM DD) Number of days:

6. Did you recommend home nursing care? ☐ Yes ☐ No If yes, for which type of services?

7. Did the insured person previously consult you or another professional for the condition requiring hospitalization or surgery before (YYYY MM DD) ? ☐ Yes ☐ No

   If yes, please provide the following information:

Name of attending physician	Date(s) of visits	Diagnosis	Treatments
	YYYY MM DD		
	YYYY MM DD		
	YYYY MM DD		

8. Was the convalescence prescribed following a delivery? ☐ Yes ☐ No

   If yes, was the insured person hospitalized at your recommendation for more than seven (7) days **after** delivery due to complications?

   ☐ Yes ☐ No If yes, please indicate the:

   a) Number of days in hospital (after delivery): days

   b) Details of complications:

Name and address of the attending physician (PLEASE PRINT)

Licence No.:

Telephone No.: (Area code + number)

Signature of attending physician: Date:

98130E (07-01)

® Registered trademark owned by Desjardins Financial Security Life Assurance Company

For all benefits claimed	1. You must submit the original receipt which includes all details of services rendered.
	2. When the space available is not sufficient, you may attach a separate sheet which you must date and sign.

E - DOMESTIC ASSISTANCE SERVICES - TO BE COMPLETED BY THE MEMBER

Date(s) of services (YYYY MM DD)	Details of services	Number of days	Fees per day
			$
			$
			$

Name of provider:

Address:

Telephone: (Area code + number)

Relationship to member: ☐ FRIEND ☐ FAMILY MEMBER ☐ OTHER, please specify:

F - HOME NURSING CARE - TO BE COMPLETED BY THE MEMBER

What services were provided?	Date(s) of services (YYYY MM DD)	Hourly rate	Number of hours	Amount
				$
				$
				$

Name of the nurse:

Address:

Licence No.: Telephone: (Area code + number)

Relationship to member: ☐ FRIEND ☐ FAMILY MEMBER ☐ OTHER, please specify:

G - STAY IN A CONVALESCENT FACILITY

Name and address of the convalescent facility	Duration of stay	Amount
	from (YYYY MM DD) to (YYYY MM DD)	$

H - CUSTODIAL SERVICES - TO BE COMPLETED BY THE MEMBER

Date(s) of services (YYYY MM DD)	Name of child	Date of birth (YYYY MM DD)	Amount claimed	Amount normally paid for child care
			$	$
			$	$
			$	$

Name of baby-sitter:

Address:

Telephone No.: (Area code + number)

Relationship to member: ☐ FRIEND ☐ FAMILY MEMBER ☐ OTHER, please specify:

I - TRANSPORTATION EXPENSES

Only eligible following surgery or hospitalization
To be completed by the member and signed by each physician or health professional consulted

Dates (YY / MM / DD)	Round-trip transportation used	Soins prodigués		Name, address and licence No. of physician or professional
	$ Taxi km Private car $ Parking $ Public transit		Signature of physician or professional	
	$ Taxi km Private car $ Parking $ Public transit		Signature of physician or professional	
	$ Taxi km Private car $ Parking $ Public transit		Signature of physician or professional	