

A - GENERAL INFORMATION - TO BE COMPLETED BY THE MEMBER

Member's first name and last name		Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth YYYY MM DD	Policy or group or contract No.
Address	Number, street, apartment		Postal code	
	City, province		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)) <input type="checkbox"/> Hospitalization <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes: Name of the insurer: _____ Contract No.: _____				
4. Was Sigma Assistel contacted before services were received? <input type="checkbox"/> Yes <input type="checkbox"/> 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: _____
Area code + Number Area code + Number

Telephone Nos: Home: _____ Office: _____ 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: _____		Discharge date: _____		
Name of hospital: _____				
4. Check the loss of autonomy criteria justifying a period of convalescence:				
<input type="checkbox"/> Eating	- The insured person needs assistance in preparing meals or feeding himself.			
<input type="checkbox"/> Moving	- The insured person needs assistance in getting out of a bed or a chair, lying down or sitting.			
<input type="checkbox"/> Dressing	- The insured person needs assistance in putting on or taking off his clothes and his orthopedic prosthesis.			
<input type="checkbox"/> 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 _____	to _____	Number of days: _____		
6. Did you recommend home nursing care? <input type="checkbox"/> Yes <input type="checkbox"/> 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 _____? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If yes, please provide the following information:				
Name of attending physician	Date(s) of visits YYYY MM DD	Diagnosis	Treatments	
_____	YYYY MM DD	_____	_____	
_____	YYYY MM DD	_____	_____	
8. Was the convalescence prescribed following a delivery? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If yes, was the insured person hospitalized at your recommendation for more than seven (7) days after delivery due to complications?				
<input type="checkbox"/> Yes <input type="checkbox"/> 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.: _____
_____				Area code + number
_____				Telephone No.: _____
Signature of attending physician:				Date:

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
_____ YYYY MM DD	_____	_____	\$ _____
_____ YYYY MM DD	_____	_____	\$ _____
_____ YYYY MM DD	_____	_____	\$ _____

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
_____	_____ YYYY MM DD	_____	_____	\$ _____
_____	_____ YYYY MM DD	_____	_____	\$ _____
_____	_____ YYYY MM DD	_____	_____	\$ _____

Name of the nurse: _____
 Address: _____
 _____ Telephone: _____
Area code + number

Licence No.: _____
 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 DD YYYY MM DD	Amount
_____	_____ from _____ to _____	\$ _____

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
_____ YYYY MM DD	_____	_____ YYYY MM DD	\$ _____	\$ _____
_____ YYYY MM DD	_____	_____ YYYY MM DD	\$ _____	\$ _____
_____ YYYY MM DD	_____	_____ YYYY MM DD	\$ _____	\$ _____

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	_____	_____
_____	\$ _____ Taxi	_____	_____
_____	_____ km \$ _____ Private car Parking	_____	_____
_____	\$ _____ Public transit	_____	_____
_____	\$ _____ Taxi	_____	_____
_____	_____ km \$ _____ Private car Parking	_____	_____
_____	\$ _____ Public transit	_____	_____