

**TO EXPEDITE YOUR CLAIM, PLEASE ANSWER ALL THE QUESTIONS.  
 (This claim will be delayed and may be returned to you if there is missing or incorrect information)**

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

<b>B</b>	<b>Are the claims the result of:</b>	
	• a work injury? <input type="checkbox"/> Yes <input type="checkbox"/> No	• a motor vehicle accident? <input type="checkbox"/> Yes <input type="checkbox"/> No
	If "Yes": • Please note that the claim must first be submitted under your provincial workers' compensation plan or automobile insurance plan before being submitted to your group plan.	
• Name of Injured Person _____		Date of accident YY   MM   DD

<b>C</b>	<b>COORDINATION OF BENEFITS (this section MUST BE COMPLETED if claiming for a spouse or child)</b>	
	1. A spouse must first submit to his or her own insurer and provide Desjardins Financial Security Life Assurance Company with the details of the benefits paid by his or her plan (i.e. the Explanation of Benefit from the spouse's insurer including copies of the receipts).	
	2. 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.	
	<b>Is your spouse insured under another insurance contract that provides benefits for:</b>	
• 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
If "Yes", is the coverage: <input type="checkbox"/> individual		EFFECTIVE DATE: YY   MM   DD
<input type="checkbox"/> family		TERMINATION DATE: YY   MM   DD
		Full name of spouse: _____
		Date of birth: YY   MM   DD
Name of insurer _____		Policy No. _____
		Identification or Certificate No. _____

<b>D</b>	<b>PATIENT INFORMATION for the period in which expenses were incurred (Use one line per patient)</b>						<b>CHILDREN AGED 18 OR 21 OR OLDER (the specific age depends on the plan provisions)</b>		
	Last Name	First Name	Partic- pant	Spouse	Child	Sex	Date of Birth	Full-time Student	Name of Educational Institution Attended
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	M F	YY   MM   DD	<input type="checkbox"/> Yes <input type="checkbox"/> No From YY   MM   DD To YY   MM   DD	
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	M F	YY   MM   DD	<input type="checkbox"/> Yes <input type="checkbox"/> No From YY   MM   DD To YY   MM   DD	
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	M F	YY   MM   DD	<input type="checkbox"/> Yes <input type="checkbox"/> No From YY   MM   DD To YY   MM   DD	
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	M F	YY   MM   DD	<input type="checkbox"/> Yes <input type="checkbox"/> No From YY   MM   DD To YY   MM   DD		

<b>E</b>	<b>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</b>		
	Name and address of the financial institution	Transit number	Account number

<b>F</b>	<b>HEALTH SPENDING ACCOUNT</b>	
	Complete this section if you have this coverage (you may wish to coordinate benefits with your spouse's plan before using your health spending account)	
Should the portion of expenses not covered under your contract be applied against your health spending account? <input type="checkbox"/> Yes <input type="checkbox"/> No		

