



**TOTAL DISABILITY BENEFITS CLAIM**  
**INSURED PERSON'S STATEMENT**

FINANCIAL SERVICES INCLUDING INSURANCE,  
ANNUITIES, CREDIT AND RELATED SERVICES

CONTRACT NUMBER: \_\_\_\_\_

<b>NAME AND ADDRESS OF INSURED PERSON</b>	_____		Date of birth		
	_____		YY	MM	DD
	Postal code		Certificate or identification number		
			Telephone numbers		
<b>MAIDEN NAME</b>	_____		Home: ( )		
<b>NAME AND ADDRESS OF EMPLOYER</b>	_____		Office: ( )		
	Postal code		Profession		

1- DATE ON WHICH YOU STOPPED WORKING AS A RESULT OF THIS ILLNESS OR ACCIDENT	YY	MM	DD
2- IF YOU HAVE RETURNED TO WORK, INDICATE THE DATE OF THE RETURN TO WORK	YY	MM	DD
3- IF YOU HAVE NOT RETURNED TO WORK, INDICATE THE APPROXIMATE OR SCHEDULED DATE OF RETURN TO WORK	YY	MM	DD
4- NATURE OF DISABILITY			
_____			
5- HAVE YOU BEEN TREATED FOR THIS ILLNESS OR ACCIDENT BEFORE? <input type="checkbox"/> YES <input type="checkbox"/> NO IF SO, INDICATE DATES, TYPE OF TREATMENTS, AND NAMES AND ADDRESSES OF PHYSICIANS			
_____			
6- WAS THIS ACCIDENT: WORK RELATED? <input type="checkbox"/> YES <input type="checkbox"/> NO AN AUTOMOBILE ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO - PLEASE ATTACH THE POLICE REPORT			
7- DESCRIPTION OF THE ACCIDENT			
_____			
8- PLEASE EXPLAIN HOW YOUR DISABILITY PREVENTS YOU FROM WORKING			
_____			
9- DESCRIBE BRIEFLY YOUR PRESENT DAILY ACTIVITIES			
_____			
10- A) IF YOU ARE PRESENTLY UNEMPLOYED, AT WHICH DATE DO YOU EXPECT TO RESUME YOUR USUAL OCCUPATIONS?	YY	MM	DD
B) IS YOUR JOB BEING HELD FOR YOU? <input type="checkbox"/> YES <input type="checkbox"/> NO IF NOT, WHY?			
_____			
11- NAMES AND ADDRESSES OF THE PHYSICIANS WHO ARE TREATING OR HAVE TREATED YOU DURING YOUR DISABILITY			
_____			
12- HAVE YOU BEEN HOSPITALIZED? <input type="checkbox"/> YES <input type="checkbox"/> NO IF SO, SPECIFY DATES:			
13- NAME OF HOSPITAL			
_____			
14- HAVE YOU UNDERGONE SURGERY? <input type="checkbox"/> YES <input type="checkbox"/> NO IF SO, INDICATE DATE OF SURGERY:	YY	MM	DD
15- TYPE OF SURGERY			
_____			

# TOTAL DISABILITY BENEFITS CLAIM (cont'd)

16- HAVE YOU APPLIED FOR ANY OTHER BENEFITS? PLEASE COMPLETE THIS SECTION

Have you filed a claim with the following organizations?	Date of your claim	Was your claim accepted?	Monthly amount
RÉGIE DES RENTES DU QUÉBEC <input type="checkbox"/> YES: <input type="checkbox"/> DISABILITY <input type="checkbox"/> RETIREMENT <input type="checkbox"/> NO	YY MM DD	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNDER REVIEW	\$
CANADA PENSION PLAN <input type="checkbox"/> YES: <input type="checkbox"/> DISABILITY <input type="checkbox"/> RETIREMENT <input type="checkbox"/> NO	YY MM DD	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNDER REVIEW	\$
SOCIÉTÉ DE L'ASSURANCE AUTOMOBILE DU QUÉBEC <input type="checkbox"/> YES <input type="checkbox"/> NO	YY MM DD	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNDER REVIEW	\$
WORKERS' COMPENSATION BOARD (CSST, WCB, WSIB, WHSCC) <input type="checkbox"/> YES <input type="checkbox"/> NO	YY MM DD	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNDER REVIEW	\$
RETIREMENT PLAN (PENSION FUND) <input type="checkbox"/> YES <input type="checkbox"/> NO	YY MM DD	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNDER REVIEW	\$
OTHER: <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> COMPANY: _____ <input type="checkbox"/> ASSOCIATION: _____ FILE OR POLICY NO.: _____ IS THIS: <input type="checkbox"/> INDIVIDUAL INSURANCE? <input type="checkbox"/> GROUP INSURANCE?		<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNDER REVIEW  <input type="checkbox"/> WAIVER OF PREMIUMS	\$

**You must provide us with the notice of acceptance or refusal for the claim you filed if such notices have not been forwarded to us yet.**

17- DO YOU HAVE OTHER SOURCES OF INCOME?  YES  NO IF SO, SPECIFY:  
 SALARY  PAID VACATION  SICK LEAVE  UNEMPLOYMENT INSURANCE  OTHER: \_\_\_\_\_  
 WEEKLY AMOUNT: \$ \_\_\_\_\_

18- DO YOU HAVE ANY OTHER INSURANCE COVERAGE WITH DESJARDINS FINANCIAL SECURITY?

CHECK APPROPRIATE BOX: POLICY OR CONTRACT NO. - IDENTIFICATION NO.

PERSONAL (INDIVIDUAL) INSURANCE \_\_\_\_\_

GROUP INSURANCE COVERAGE THROUGH YOUR EMPLOYER \_\_\_\_\_

LOAN INSURANCE AT YOUR CAISSE OR CREDIT UNION \_\_\_\_\_

ACCIRANCE - ACCIDENT INSURANCE \_\_\_\_\_

DESJARDINS POPULAR INSURANCE \_\_\_\_\_

OTHER \_\_\_\_\_

19- DO YOU HAVE A MORTGAGE LOAN WITH DESJARDINS FINANCIAL SECURITY?  YES  NO - CONTRACT NO.: \_\_\_\_\_

## PERSONAL INFORMATION MANAGEMENT

Desjardins Financial Security (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, 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.

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

### To be completed for each claim

I certify that the above answers are complete and true. I authorize Desjardins Financial Security, strictly for the purposes of determining my insurability, managing my file and settling my claims 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, the Medical Information Bureau, insurance companies, personal information officers or investigation agencies, the policyholder, my employer or former employers; 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, request an inquiry report about me, and also use the personal information it may have about me in existing files that are now closed. A photocopy of this authorization is as valid as the original.

Signature of  
the insured person

Date