

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

A Policy or Group or Contract No.	Identification or Certificate No. or S.I.N.			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 YY MM DD			
Number, Street, Apartment				In force	Individual	YY MM DD
City, Province					Family	YY MM DD
				Name of Group or Policyholder or Employer		
Postal Code						
				Date		

B Are the claims the result of:

• a work injury? Yes No • a motor vehicle accident? Yes No

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.

Date of accident: YY | MM | DD

• Name of injured person _____

C COORDINATION OF BENEFITS (this section MUST BE COMPLETED if claiming for a spouse or child)

- 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).
- 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.

Is your spouse insured under another insurance contract that provides benefits for:

• drugs: Yes No • paramedical services: Yes No • vision care: Yes No

If "Yes", is the coverage: individual EFFECTIVE DATE: YY | MM | DD Full name of spouse: _____
 family TERMINATION DATE: YY | MM | DD Date of birth: YY | MM | DD

Name of insurer _____ Policy No. _____ Identification or Certificate No. _____

D PATIENT INFORMATION for the period in which expenses were incurred (Use one line per patient) 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.							CHILDREN AGED 18 OR 21 OR OLDER (the specific age depends on the plan provisions)	
Last Name	First Name	Participant	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	

**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

F HEALTH SPENDING ACCOUNT
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? Yes No

