

**CLAIM**

- ACCIDENTAL DISMEMBERMENT OR LOSS OF SIGHT
- FRACTURES

**IMPORTANT** – Settlement of this claim will be possible only if an adequate answer is given to all questions on this form.

**EMPLOYER'S STATEMENT**

Name and address of employer		Contract/Group No.		Account/Division No.	
		Telephone No. ( )		Ext.	
Date of hiring YY MM DD		Coverage effective date YY MM DD		Does the employee work on a part-time basis (more than 25% and less than 75% of time)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
				If so, specify the % com- pared to full-time work %	
Was the insured disabled before the event? <input type="checkbox"/> Yes <input type="checkbox"/> No		Date of beginning of disability YY MM DD		Last date worked YY MM DD	
				Salary at beginning of disability	
				Annual salary at the date of the event	
Remarks					
<b>I hereby certify that the information given is complete and true.</b>					
Signature of employer's representative		Title		Date	

**INSURED'S STATEMENT**

<b>DOCUMENTS REQUIRED</b>	<b>ACCIDENTAL DISMEMBERMENT OR LOSS OF SIGHT</b> <input type="checkbox"/> Insured child's birth certificate	<b>FRACTURES</b> <input type="checkbox"/> Insured child's birth certificate <input type="checkbox"/> X-ray
<b>You may reach us at the following telephone numbers:</b> Toronto area: (416) 926-2990 Toll free number: 1-800-263-1810		

**A - IDENTIFICATION - Please print**

1- Last name of <u>insured</u>		2 - First name	
3 - Address - No., Street		City	Province
			Postal Code
4 - Telephone Nos.	Home: ( )	Work: ( )	Ext.
5 - Last name of <u>injured person</u> (If other than the insured)		6 - First name	
7 - Address - No., Street		City	Province
			Postal Code
8 - Telephone Nos.	Home: ( )	Work: ( )	Ext.

**B - INSURED CHILD - If aged between 18 and 25 inclusively or between 21 and 25 inclusively (according to contract)**

Is he/she a full-time student?  Yes  No If yes, provide name and address of educational institution:

**C - DETAILS ABOUT THE ACCIDENT**

1 - Date of accident: YY MM DD	2 - Was the injured person: <input type="checkbox"/> the driver <input type="checkbox"/> a passenger
3 - Is it: <input type="checkbox"/> a work-related accident <input type="checkbox"/> a motor vehicle accident	<input type="checkbox"/> an occupational illness <input type="checkbox"/> other, please specify:
4 - Brief description of accident	

**D - DESCRIPTION OF INJURIES**

1 - Brief description of injuries

2 - Did the injured person undergo surgery?  Yes  No If yes, please specify:  
Type of surgery: Date of surgery: YY MM DD

**E - DECLARATION AND AUTHORIZATION OF INSURED**

<b>DIRECT DEPOSIT</b> - If you want your benefits to be deposited directly into your account, complete this section and enclose a void cheque	Identification No. (transit)	Account No.
I certify that the above answers are complete and true. I acknowledge that I have read the notice on the reverse of this form regarding the personal information management.		
Signature of insured		Date

**F - AUTHORIZATION FOR THE COLLECTION AND COMMUNICATION OF PERSONAL INFORMATION**

I authorize Desjardins Financial Security Life Assurance Company, strictly for the purposes of 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. This authorization is also valid for the collection, use and communication of personal information concerning my minor children, insofar as applicable to the claim. A photocopy of this authorization is as valid as the original.

Signature of injured person (14 years old or older) DATE

**AND** Signature of father, mother or guardian if this person is under the age of majority

**ATTENDING PHYSICIAN'S STATEMENT**

Fees charged for this statement are to be paid by the insured.

- ACCIDENTAL DISMEMBERMENT OR LOSS OF SIGHT
- FRACTURES

**SECTION TO BE COMPLETED BY INSURED**

**A - IDENTIFICATION**

1 - Last name of <u>injured person</u>	2 - First name	3 - Date of birth YY MM DD
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**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 the Company's various financial services (insurance, annuities, credit, etc.). 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 send information on its insurance products for retirees to those whose names appear on its client list. 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.

**SECTION TO BE COMPLETED BY PHYSICIAN**

**C - GENERAL INFORMATION**

1 - Date of accident: YY MM DD		
2 - Did the total and irremediable loss occur during the 365-day period following the accident? <input type="checkbox"/> Yes <input type="checkbox"/> No		
3 - Is it: <input type="checkbox"/> a work-related accident <input type="checkbox"/> an occupational illness <input type="checkbox"/> a motor vehicle accident <input type="checkbox"/> other, please specify:		
4 - Description of loss or fracture - Please mention the ICD code <span style="border: 1px solid black; padding: 2px;">Join an interpretation of the X-ray</span>		
5 - If there is a dismemberment or loss of use, specify the level of amputation or % of loss of use		Date YY MM DD
6 - Loss of sight at last examination dated: YY MM DD		7 - Is the loss of use the direct result of the accident and independent of any other cause? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If no</b> , please explain:  _____  _____  _____
(a) Visual acuity	Left eye	
(b) Acuity with glasses	Right eye	
(c) Vision may be fully or partially corrected by:	<input type="checkbox"/> Glasses <input type="checkbox"/> Glasses <input type="checkbox"/> Treatment <input type="checkbox"/> Treatment <input type="checkbox"/> Operation <input type="checkbox"/> Operation <input type="checkbox"/> No method <input type="checkbox"/> No method	
8 - At the time of the accident, did the insured take: medication? <input type="checkbox"/> Yes <input type="checkbox"/> No      drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No      alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, please provide us tests results.		
9 - Other attending physicians		
NAME	ADDRESS	DATE
NAME	ADDRESS	DATE
NAME	ADDRESS	DATE
10 - Hospitals or other institutions where care were rendered		
NAME	ADDRESS	DATE
NAME	ADDRESS	DATE
NAME	ADDRESS	DATE
11 - Comments  _____		
Name and address of physician (PLEASE PRINT)		Signature of physician
		Date
		Specialty
		Licence No.
Postal code		Telephone No. ( ) -      Fax No. ( ) -

**THANK YOU FOR YOUR ASSISTANCE**