Desjardins Insurance
LIFE • HEALTH • RETIREMENT

PO Box 4593 STN A
Toronto ON M5W 4X7

GROUP INSURANCE - DISABILITY CLAIMS

DISABILITY OR WAIVER OF PREMIUM CLAIM
EMPLOYEE STATEMENT

A - IDENTIFICATION

We are unable to assess this claim unless all questions are answered completely.

Last name and first name of employee			Sex ☐ M ☐ F	Date of birth YYYY MM DD
Address - no., street, apt.	City		Province	Postal code
Policy no.	Division no.	Certificate or identification no.	Social insurance no.	
Home telephone no.: ( ) -				

B - GENERAL INFORMATION

1. Training:

Level of education:

Work experience:

Spoken language: ☐ English ☐ French Written language: ☐ English ☐ French

2. Is disability due to an accident? ☐ Yes ☐ No	**If "Yes"**, date of accident YYYY MM DD	Time ☐ AM ☐ PM	Type of accident ☐ Work-related ☐ Motor vehicle ☐ Other

Indicate details (where, how and witnesses).

3. Did you receive prior treatment for the illness or injury causing the disability? ☐ Yes ☐ No
If "Yes", give particulars including name, address and telephone number of all treating physicians and specialists.

4. Name, address and telephone number of physicians and specialists who have treated you during the disability.

PLEASE COMPLETE THE BACK OF THE FORM

B - GENERAL INFORMATION (CONT'D)

5. If you have any accident or sickness coverage through a union, society, creditor, mortgage, auto, lodge or other association, through another employer, under an individual policy, give the following particulars:

Name of insurer	Policy no.	Certificate no.	Date benefits commence	Benefit period	Benefit amount	Weekly/Monthly
			YYYY MM DD	FROM: TO:		☐ W ☐ M
			YYYY MM DD	FROM: TO:		☐ W ☐ M

COMMENTS: _____

I hereby certify that the above answers are full and true.

SIGNATURE OF EMPLOYEE **DATE**

C - 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.

D - AUTHORIZATION FOR THE COLLECTION AND COMMUNICATION OF PERSONAL INFORMATION

To be completed for each claim.

I authorize Desjardins Financial Security Life Assurance Company, 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 MIB (formerly known as 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. I authorize Desjardins Financial Security Life Assurance Company to use or communicate my social insurance number for administrative purposes. A photocopy of this authorization is as valid as the original.

SIGNATURE OF EMPLOYEE **DATE**

VERY IMPORTANT

PLEASE HAVE THE INITIAL ATTENDING PHYSICIAN'S STATEMENT COMPLETED AND FORWARD COMPLETED FORMS TO DESJARDINS FINANCIAL SECURITY LIFE ASSURANCE COMPANY, DISABILITY CLAIMS.

PRINT NEW REQUEST