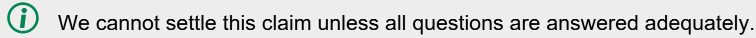
Desjardins Insurance
Life • Health • Retirement

200, rue des Commandeurs
Lévis (Québec) G6V 6R2

Accidental Dismemberment or Loss of Sight Claim Form



A. Information about the insured

Last name	First name		
Address – No., street, apt.	City	Province	Postal code
10-digit phone number (home)	10-digit phone number (work)		Extension

Employer of principal insured	Contract/group no.	Account/division no.	Identification no. of the insured

Last name of injured person (If other than the insured)	First name		
Address – No., street, apt.	City	Province	Postal code
10-digit phone number (home)	10-digit phone number (work)		Extension

B. Insured child

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

C. Details about the accident

Date of accident (YYYY-MM-JJ)	Was the injured person: ☐ the driver ☐ a passenger

Is it: ☐ a work-related accident ☐ an occupational illness
☐ a motor vehicle accident ☐ other, please specify:

Brief description of accident

D. Description of injuries

Brief description of injuries

Did the injured person undergo surgery? ☐ Yes ☐ No If **yes**, please specify:

Type of surgery	Date of surgery (YYYY-MM-JJ)

E. Declaration of insured

DIRECT DEPOSIT – 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.

DECLARATION – I declare that the information provided above is complete and true. I acknowledge that I have read the notice on the reverse of this form regarding the personal information management.

X ______________________________ ______________________
Signature of insured Date (YYYY-MM-JJ)

F. Authorization to collect and communicate personal information

For the sole purpose of determining insurability, managing files and processing claims, I authorize Desjardins Insurance or its reinsurers: (a) to collect from any individual, legal entity or public or parapublic organization only the personal information they have about me that is needed to process my file. This information may be collected from third parties, including any health care professional or establishment, MIB, LLC, insurance and reinsurance companies, personal information brokers, investigation firms, the contract holder, my employer or my former employers; (b) to disclose to those individuals, legal entities or public or parapublic organizations only the personal information they have about me that is needed to manage my file; (c) to request, if applicable, an investigation report about me and to use the personal information contained in other files it may have that are now closed; (d) to disclose to my personal physician any medical information about me that was obtained during the evaluation of my file; (e) to disclose to other insurers or reinsurers any information about me that is relevant to determining my eligibility for insurance or for benefits; (f) to provide a brief report on my personal information, including my health information, to MIB, LLC. This authorization also applies to the collection, use and communication of personal information regarding my dependents, insofar as applicable to my claim. A photocopy of this authorization is as valid as the original.

X ______________________________ ______________________

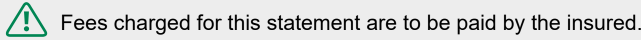
Signature of injured person (14 years old or older)

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

Date (YYYY-MM-JJ)

G. Personal information management

Desjardins Insurance handles the personal information it has on you in a confidential manner. Desjardins Insurance keeps this information on file so that you may benefit from group insurance services offered by the Company. This information is consulted solely by Desjardins Insurance employees who need to do so in the course of their work. Desjardins Insurance may compile anonymized personal information for statistical and informational purposes. Desjardins Insurance may also communicate with plan members to provide them with optimal health management. 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 Insurance, 200, rue des Commandeurs, Lévis, Québec, G6V 6R2. Desjardins Insurance 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 Desjardins Insurance.



Attending Physician's Statement

Accidental Dismemberment or Loss of Sight

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

A. Information about the injured person- Section to be completed by insured

Last name	First name	Date of birth (YYYY-MM-JJ)

B. General information

1. Date of accident (YYYY-MM-JJ)

2. If there is a loss of use, is it total and permanent?
☐ Yes ☐ No

3. Did the total and permanent loss occur during the 365-day period following the accident?
☐ Yes ☐ No

4. Is it: ☐ a work-related accident ☐ an occupational illness
☐ a motor vehicle accident ☐ other, please specify:

5. Description of loss - Please mention the ICD code

6. If there is a dismemberment or loss of use, specify the level of amputation or % of loss of use — Date (YYYY-MM-JJ)

7. Loss of sight at last examination dated (YYYY-MM-JJ): ______

	Left eye	Right eye
a) Visual acuity		
b) Acuity with glasses		
c) Vision may be fully or partially corrected by	☐ Glasses ☐ Treatment ☐ Operation ☐ No method	☐ Glasses ☐ Treatment ☐ Operation ☐ No method

8. Is the loss of use the direct result of the accident and independent of any other cause?
☐ Yes ☐ No If **no**, please explain:

9. At the time of the accident, did the insured take:
medication? ☐ Yes ☐ No drugs? ☐ Yes ☐ No alcohol? ☐ Yes ☐ No
If so, please provide us tests results

10. Other attending physicians:

Name	Address	Date (YYYY-MM-DD)

11. Hospitals or other institutions where care were rendered:

Name	Address	Date (YYYY-MM-DD)

12. Comments

C. Identification of physician

Last name	First name	License number

10-digit phone number	10-digit fax number

☐ General practitioner ☐ Specialist Specify:

X ______________________ Signature

______________________ Date (YYYY-MM-JJ)