Desjardins Insurance
Life • Health • Retirement

C. P. 3950
Lévis (Québec) G6V 8C6
desjardinslifeinsurance.com/planmember
1-800-263-1810



# WELLNESS ACCOUNT CLAIM

In order for us to process your claim, please answer **all questions** that apply to your situation and **sign section D**.

**Claims MUST BE submitted no later than 12 months after expenses are incurred.**

## Section A. Identification (mandatory section) – Policy or group or contract number concerning your Wellness Account is available from your employer.

| **Policy or group or contract no.** | **Certificate no.** | Name of group or policyholder or employer |
|---|---|---|
| | | |

| Member's last name and first name | Date of birth (YYYY MM DD) |
|---|---|
| | |

| Address – Number, street, apartment | City | Province | Postal code |
|---|---|---|---|
| | | | |

## Section B. Wellness account – The claims expenses must be submitted only when fully paid.

- Attach your original receipts to this form and keep copies for your files. The original copies will not be returned.
- The receipts must be issued under the name of the service beneficiary and indicate the name and address of the service provider.

| **1. Last name and first name of the service beneficiary** | **Relationship to the member** |
|---|---|
| | |

| **Description of the service** | **Name of the service provider** | **Date of fees** (YYYY MM DD) | **Amount claimed** |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

| **2. Last name and first name of the service beneficiary** | **Relationship to the member** |
|---|---|
| | |

| **Description of the service** | **Name of the service provider** | **Date of fees** (YYYY MM DD) | **Amount claimed** |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

## Section C. Personal information management

To serve you effectively every day and fulfill our legal obligations, we need to collect, use and disclose information about you. You can read Desjardins Group's Privacy Policy at www.desjardins.com/privacy-policy for full details on how your personal information is processed. Specific consents may be required to begin and maintain a business relationship with Desjardins Financial Security Life Assurance Company, hereinafter Desjardins Insurance. These steps will be taken in compliance with Desjardins Group's Privacy Policy. Desjardins Insurance handles the personal information it has on you in a confidential manner. Access to your file is limited to authorized personnel who need it to access it to perform their duties. Desjardins Insurance may also communicate with plan members to provide them with optimal health management (management claim tools, informative health documentations, etc.) and offer its clients an insurance product following the termination of their group insurance. You have the right to review your personal information in our files and correct anything that is incomplete, ambiguous or not relevant. To do so, please consult our Privacy Policy.

## Section D. Declaration and authorization for the collection, use and communication of personal information

All the information I have provided on the claim form is accurate and complete. I acknowledge having read the Personal Information Management section. I authorize Desjardins Insurance, strictly for the purposes of managing my file and settling this claim 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, insurance companies; (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 use the personal information it may have about me in existing files that are now closed. To achieve the purposes described above and to provide you support, your information, on a depersonalized basis, may be used for analysis, statistics and development of predictive models. This authorization is also valid for the collection, use and communication of personal information concerning my dependents, insofar as applicable to the claim. A photocopy of this authorization is as valid as the original.

**Signature of the member** ______________________________ **Date** ______________

Telephone nos: Home: ______________________ Office: ______________________ Extension: ______________

**Please send to: Desjardins Insurance, C. P. 3950, Lévis (Québec) G6V 8C6**



Desjardins Insurance refers to Desjardins Financial Security Life Assurance Company.