

CLAIM FOR DENTAL CARE EXPENSES

A DENTIST INFORMATION

Last name and first name	Member number	Telephone number
Address – No., street, suite	City	Province
		Postal code

B CLAIM INFORMATION Predetermination Bill

IMPORTANT: If the claim is for dental treatment due to an accident please refer to section I. If the treatment requires more than one session, the date of treatment must be the date on which the treatment terminates or the insertion date.

Last name and first name of the patient							Date of birth YYYY MM DD			Relationship to the member <input type="checkbox"/> Spouse <input type="checkbox"/> Daughter <input type="checkbox"/> Son		
Treatment date YY MM DD	Tooth No.	Procedure code	Tooth surface	Laboratory expenses	Dentist's fees	Total charge	Diagnosis – This section is reserved for the dentist: THIS IS AN ACCURATE STATEMENT OF SERVICES PERFORMED AND FEES CHARGED.					
Total fee claimed:							Signature of dentist: _____ Date: _____					

C ASSIGNMENT OF BENEFITS

I hereby assign benefits payable from this claim to the above named dentist and authorize Desjardins Financial Security Life Assurance Company, hereinafter Desjardins Insurance, to pay the dentist directly.

Signature of member: _____ Date: _____

D MEMBER INFORMATION – To be completed by the member. If you don't know your group No. or certificate No., please click .

Group name and group No.				Certificate No. or student identification No.			
Member's last name and first name				Sex <input type="checkbox"/> M <input type="checkbox"/> F		Date of birth YYYY MM DD	
Address – No., street, apartment				City		Province	
						Postal code	




Complete only if you are claiming expenses incurred for your dependent children aged 21 and over. Remember to include the information for the period in which the expenses were incurred for your child. If your child has a functional impairment, please provide us with a medical certificate confirming your child's disability.

Has a functional impairment YYYY MM DD

Full-time student – Name of educational institution attended: _____ Period: From _____ To _____

E COORDINATION OF BENEFITS – To be completed by the member. This section must be completed if the claim is for yourself, a spouse or child, and if your spouse is insured under another insurance plan that provides dental care benefits.

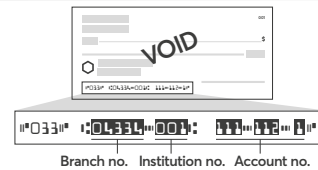
Last name and first name of person who has the other insurance plan				Sex <input type="checkbox"/> M <input type="checkbox"/> F		Date of birth YYYY MM DD	
Name of insurer <input type="checkbox"/> Other <input type="checkbox"/> Desjardins Insurance – Contract No.: _____ Certificate No.: _____				Period of coverage From _____ To _____			
Type of dental coverage: <input type="checkbox"/> Individual <input type="checkbox"/> Couple <input type="checkbox"/> Single-parent <input type="checkbox"/> Family							
Last name and first name of the dependents covered under this other insurance plan							

-  Claims for expenses must be submitted within 12 months of the date they are incurred.
-  Please sign section H and send the form to: Desjardins Insurance, C. P. 3950, Lévis (Québec) G6V 8C6
-  For specific details regarding your plan, please visit aseq.ca.

PLEASE COMPLETE THE BACK OF THIS FORM.

F DIRECT DEPOSIT SERVICE – Attach a void cheque or provide your bank information below to sign up for direct deposit.

Transit/branch No.	Institution No.	Account No.
Your email address (mandatory)		



Once registered, your reimbursements for health care services will be deposited into this bank account. A notification email will be sent once your claims have been processed, and the explanation of benefits will be posted online rather than mailed. You must be registered on the secure site to consult your explanation of benefits. To register, go to desjardinslifeinsurance.com/planmember.

Desjardins Insurance is not responsible for the accuracy of the banking information you enter and for verifying that the due amounts are deposited into your account.

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.

H DECLARATION AND AUTHORIZATION FOR THE COLLECTION AND COMMUNICATION OF PERSONAL INFORMATION

I understand that I am responsible for the total cost of the treatment. 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.

I also authorize Desjardins Insurance to release the information regarding this claim to ASEQ for benefits administration. 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: _____

I DENTAL TREATMENT DUE TO AN ACCIDENT

► **TO BE COMPLETED BY THE MEMBER**

YYYY MM DD

Date of the accident: _____ Location of the accident: _____

How did the accident occur? _____

If the claim is the result of a work injury or a motor vehicle accident, please note that the claim must first be submitted to your provincial automobile insurance (if applicable in your province) or occupational health and safety plan before being forwarded to your insurer.

► **TO BE COMPLETED BY THE DENTIST**

Is it an accidental injury to a healthy and natural tooth? Yes No

Diagnosis and clinical description prior to the accident: _____

Preoperative X-rays are required for the study of dental treatment due to an accident. They will be returned to the attending dentist as soon as possible.

Please sign section H and send to: Desjardins Insurance, C. P. 3950, Lévis (Québec) G6V 8C6