Desjardins Financial Security®

C. P. 3950
Lévis (Québec) G6V 8C6

A group benefits plan insured by Desjardins Financial Security and administered by: ONTARIO HOSPITAL ASSOCIATION

GROUP INSURANCE - HEALTH CLAIMS

CLAIM FOR DENTAL CARE EXPENSES

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DENTIST INFORMATION

Last name and first name	Member no.	Telephone no. ( ) -
No., street, office	City	Province / Postal code

CLAIM INFORMATION

IMPORTANT: If the claim is for dental care subsequent to an accident, a crown, veneer application, inlay or denture, please see the reverse side. 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 employee
		☐ Spouse ☐ Daughter ☐ Son

Date of treatment Year Month Day	Tooth no.	Procedure code	Tooth surface	Laboratory expenses	Dentist's fees	Total charge
			Total fee claimed:			

This section is reserved for the dentist's diagnosis

THIS IS AN ACCURATE STATEMENT OF SERVICES PERFORMED AND FEES CHARGED.

Signature of dentist _____

Date:

ASSIGNMENT OF BENEFITS

I assign benefits payable from this claim to the above named dentist and authorize payment directly to him.

Signature of employee: **Date:**

EMPLOYEE INFORMATION - To be completed by the employee. To expedite processing of your claim, please answer all questions.

Name of policyholder	Police no.	Certificate no.
St. Joseph's Health Centre	541102	

Employee's last name and first name	Sex ☐ M ☐ F	Date of birth YYYY MM DD

No., street, apartment	City	Province	Postal code

Complete only if you are claiming expenses incurred for your dependent children aged 18 or 21 or older (depending on the policy). 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

Full-time student or with a functional impairment:	☐ Funct. Imp. ☐ Full time Stud. : From YYYY MM DD To YYYY MM DD	Name of educational institution attended:

COORDINATION OF BENEFITS - to be completed by the employee

Last name and first name of person who has the other insurance coverage	Sex ☐ M ☐ F	Date of birth YYYY MM DD

Name of insurer ☐ DFS ☐ Other	Period of coverage From YYYY MM DD to YYYY MM DD	If the other insurer is DFS: Contract no.: Certificate no.:

Type of dental coverage: ☐ Individual ☐ Couple ☐ Single-parent ☐ Family

Last name and first name of the dependents covered under this other insurance coverage

DIRECT DEPOSIT AND ELECTRONIC NOTICE SERVICE - to be completed by the employee

- This service enables you to receive your health claim payments by direct deposit and to be informed by e-mail when your claim has been processed. **To enroll in this service**, please attach a specimen cheque marked "VOID" and provide your E-mail address:

_____

- ☐ I would like to enrol in the Direct Deposit Service, but I do not wish to receive any email notices.
- For more details on this service or to make changes to it, please visit our Web site at www.dfsgroupinsurance.com.

PLEASE COMPLETE THE BACK OF THE FORM

HEALTH SPENDING ACCOUNT - If you have this coverage, check the options you would like.

- I confirm that I am eligible for a reimbursement of the indicated expenses under my Health Spending Account.
- I recognize that I am responsible for paying any taxes that may result from the reimbursement of these expenses.
- I recognize that for tax or administrative purposes, my plan administrator may have access to a statement of expenses for which I claimed a reimbursement under my Health Spending Account.

☐ **1.** I do not wish to use my Health Spending Account.

☐ **2. Ineligible expenses -** I wish to use my Health Spending Account to cover the expenses that are not reimbursed under my group insurance.

☐ **3. Spouse's family coverage -** I wish to use my Health Spending Account for myself and my dependent children to cover the expenses that are not reimbursed under my group insurance. I will not submit a claim to my spouse's insurer (coordination of benefits).

PERSONAL INFORMATION MANAGEMENT

Desjardins Financial Security (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, 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.

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 at the back of this form. I authorize Desjardins Financial Security, 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. 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 employee: _____ Date: _____

Telephone nos: Home: ( ) - Office: ( ) - Extension:

DENTAL CARE SUBSEQUENT TO AN ACCIDENT

TO BE COMPLETED BY THE EMPLOYEE

Date of the accident: YYYY MM DD Location of the accident: _____

How did the accident occur?

_____

_____

If the claim is the result of a work injury or a motor vehicule 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

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

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

Diagnosis and clinical description prior to the accident: _____

_____

_____

CLAIM FOR A CROWN, VENEER, INLAY/ONLAY, FIXED BRIDGE OR DENTURE

- **For crown, veneer or inlay/onlay:** please submit pre-treatment x-rays. If replacement, please indicate the age of the existing appliance.
- **For fixed bridge:** please submit pre-treatment x-rays with clear views of both sides of the arch(s). If replacement, please indicate the age and type of the existing prosthesis. If initial, please indicate the extraction date of the missing teeth.
- **For denture:** if replacement, please indicate the age and type of the existing prosthesis. If initial, please indicate the extraction date of the missing teeth.

Please include a copy of the commercial lab bill with your claim.

PLEASE SEND TO: DESJARDINS FINANCIAL SECURITY, C. P. 3950, LÉVIS, QUÉBEC, G6V 8C6

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