Submit online
desjardinslifeinsurance.com/send
Complete and save the form on your computer first.
Keep original forms for your records.

By mail
PO Box 1024 STN A
Toronto ON M5W 1G5
Send original forms and keep copies for your records.

By fax
604-678-8124
1-855-678-8124 (toll free)
Keep original forms for your records.

Contact us: 416-926-2990 or 1-800-263-1810 (toll free)

Desjardins Insurance
Life • Health • Retirement

GROUP INSURANCE – DISABILITY CLAIMS

DISABILITY OR WAIVER OF PREMIUM CLAIM

EMPLOYEE STATEMENT

The payment of your disability claim will be made by direct deposit only. Please include a specimen cheque marked "VOID".

A. IDENTIFICATION

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

Last name and first name of employee	☐ PVP ☐ Management ☐ Exempt Staff	Sex ☐ M ☐ F	Date of birth YYYY MM DD
Address – No., street, apt. / City		Province	Postal code
Policy or group or contract No. 647227	School District Name / SD # / (Div. no)	Certificate or identification No.	Social insurance No.[1]

Telephone No. (mandatory): ☐ I authorize Desjardins Financial Security, hereinafter Desjardins Insurance, to leave me voicemail about my disability claim.

Email address[2]:

1. Your social insurance number is necessary only if your disability claims are taxable. Please contact your employer to obtain this information.
2. Please provide this information only if you authorize Desjardins Insurance to email you.

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):

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.

Desjardins Insurance refers to Desjardins Financial Security Life Assurance Company.

B. GENERAL INFORMATION (CONTINUED)

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.	Start date of benefits	End date of benefits	Benefit amount	Weekly/Monthly
			YYYY MM DD	YYYY MM DD	$	☐ W ☐ M
			YYYY MM DD	YYYY MM DD	$	☐ W ☐ M

Comments: _____

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 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.

D. DECLARATION AND AUTHORIZATION FOR THE COLLECTION, USE AND COMMUNICATION OF PERSONAL INFORMATION

To be completed for each claim

I hereby certify that the above answers are full and true. I authorize **Desjardins Insurance** 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 healthcare professionals or facilities, MIB, LLC, 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. 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.

Provided that I have filled out the appropriate boxes, I authorize Desjardins Insurance to email me at the address provided in section A of this form and I give Desjardins Insurance permission to leave voicemail about my disability claim at the phone number provided on this form.

I authorize Desjardins Insurance to use or communicate my social insurance number for tax purposes.

I authorize Desjardins Insurance to deposit my benefit payment using the DIRECT DEPOSIT system into my account **in accordance with the attached specimen cheque**. Any amount credited to my account under this authorization will be identified by the transaction code DIRECT DEPOSIT and I acknowledge that any amount so credited shall constitute a payment made in accordance with this authorization. This authorization is effective **as of the date of signature of this form** and will terminate following a 10-day written notice by either Desjardins or me.

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 submit the completed forms online, or by mail or fax to: Desjardins Insurance – Disability Claims.

SAVE PRINT NEW REQUEST