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

By mail:
PO Box 1203 STN A
Toronto ON M5W 1G6
Send original forms and keep copies for your records.

By fax:
1-844-409-6571 (toll free)
416-926-0697
Keep original forms for your records.

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

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	Sex	Date of birth (YYYY MM DD)
	☐ M ☐ F	

Address - No., street, apt.	City	Province	Postal code

Policy or group or contract no.	Division no.	Certificate or identification no.	Social insurance no.[1]
64090S			

Telephone no. (mandatory): ( ) -

☐ I authorize Desjardins Financial Security, hereinafter Desjardins Insurance, to leave me voicemail about my disability claim.

E-mail 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.

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 - DIRECT DEPOSIT ENROLMENT

Please include a specimen cheque marked "VOID".

I hereby authorize Desjardins Insurance to deposit my benefit payment through the DIRECT DEPOSIT system into account at the financial institution indicated below:

Name of financial institution	Institution no.	Transit/branch no.	Account no.
Address - No., street, suite	City	Province	Postal code

Any credit entered in my account in accordance with this authorization will be identified with a DIRECT DEPOSIT transaction code and I acknowledge that the credit in question shall constitute an amount paid in accordance with this authorization.

This authorization will be effective on _____ . The authorization will terminate following a 10-day written notice by either Desjardins Insurance or me.

Signature of employee: **Date:**

D - 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.

E - DECLARATION AND AUTHORIZATION FOR THE COLLECTION 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, the MIB (formerly known as Medical Information Bureau), 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.

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. 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