Desjardins Insurance
Life • Health • Retirement

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Tel.: 1-800-263-1810

CONFIRMATION OF A DEPENDENT CHILD'S FUNCTIONAL IMPAIRMENT

A IDENTIFICATION

Member's last name and first name

Policy or group or contract number

Certificate number

Dependent child's last name and first name

Sex ☐ M ☐ F

Date of birth of dependent child YYYY MM DD

Does the child live with you? ☐ Yes ☐ No

If no, where does the child live?

Name of the person the child lives with

Number, street, apartment

City

Province

Postal code

B GENERAL INFORMATION – To be completed by the member.

1. Please describe the child's functional impairment:

2. Start date of functional impairment: YYYY MM DD

3. Please describe the child's work experience:

Please describe the limitations that prevent the child from being gainfully employed:

4. Is the child eligible for government assistance because of his/her functional impairment? ☐ Yes ☐ No

If an application related to a functional impairment has been made, please indicate the decision (approval or denial) and provide us with a copy of all documents submitted to and received from the government: _____

C DECLARATION AND AUTHORIZATION FOR THE COLLECTION 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 at the back of this form. I authorize Desjardins Financial Security Life Assurance Company, hereinafter 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. 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:**

PLEASE HAVE THE CHILD'S ATTENDING PHYSICIAN COMPLETE THE BACK OF THIS FORM.

PRINT RESET

D MEDICAL INFORMATION – To be completed by the attending physician.

1. Clinical diagnosis: ☐ Permanent ☐ Temporary

2. Please describe the nature and degree of the mental or physical functional impairment:

3. Date of diagnosis: YYYY MM DD

4. To what degree does the physical or mental functional impairment prevent the child from performing his/her normal everyday activities?

5. What type of work is the child capable of doing?

6. Indicate the periods during which the child was not able to work or attend school full time because of his/her functional impairment:

First period: From YYYY MM DD To YYYY MM DD Second period: From YYYY MM DD To YYYY MM DD

Third period: From YYYY MM DD To YYYY MM DD Fourth period: From YYYY MM DD To YYYY MM DD

7. What is your prognosis with regard to the child's functional impairment?

E IDENTIFICATION OF THE PHYSICIAN – To be completed by the attending physician.

Last name and first name of the physician			License number
Number, street, suite	City	Province	Postal code
Telephone number	Fax number	Email address	

I hereby certify that the above answers are full and true.

Signature of the physician: **Date:**

F 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.