Desjardins Insurance
Life • Health • Retirement

C. P. 3950
Lévis (Québec) G6V 8C6
desjardinslifeinsurance.com/planmember

CLAIM FOR TUITION EXPENSES
STUDENT STATEMENT

PLEASE READ THE FOLLOWING CAREFULLY BEFORE COMPLETING THIS FORM.

- **Please attach to this form original receipts for your book purchases as well as fees/expenses that are mandatory, non-negotiable and non-refundable and that you no longer use following withdrawal from college or university (copies will not be accepted). Keep copies for your records, as the originals will not be returned.**
- **The explanation of benefits you receive from us, along with copies of your receipts, are acceptable proof of expense for income tax purposes and coordination of benefits with other carriers.**
- **Claims MUST be submitted within 12 months of the date they are incurred.**
- **Have your physician complete the "Claim for Tuition Expenses" form (No. 12194E).**
- **For specific details regarding your plan, please visit studentcare.ca.**

A IDENTIFICATION OF STUDENT

Last name and first name of student | Telephone No.

Group No. | Certificate No. or student ID No. | Sex ☐ M ☐ F | Date of birth YYYY MM DD

Address – No., street, apt. | City | Province | Postal code

Policyholder name

B DISABILITY DUE TO SICKNESS OR INJURY

1. Please describe the nature of your condition: _____

2. When did you first receive treatment from a physician: _____
YYYY MM DD

3. When were you first unable to attend classes?

C IDENTIFICATION OF PHYSICIANS OR HEALTHCARE PROVIDERS

Please provide the name and address of each physician or other healthcare provider involved in your medical care.

Last name and first name of physician or healthcare provider (PLEASE PRINT) | Telephone No.

Specialty | License No.

Address – No., street, suite | City | Province | Postal code

Date of latest visit YYYY MM DD | Frequency of visits ☐ Weekly ☐ Monthly ☐ Other (specify): | Date of next visit YYYY MM DD

Last name and first name of physician or healthcare provider (PLEASE PRINT) | Telephone No.

Specialty | License No.

Address – No., street, suite | City | Province | Postal code

Date of latest visit YYYY MM DD | Frequency of visits ☐ Weekly ☐ Monthly ☐ Other (specify): | Date of next visit YYYY MM DD

PLEASE COMPLETE THE BACK OF THE FORM.

D TREATMENT

1. Please describe your current treatment (surgery, physiotherapy, counselling): _____

2. If you are taking any medications, please provide the following details:

Name of medication	Dosage	Date started YYYY MM DD	Purpose of medication

3. If you are scheduled for any further referrals, blood tests, X-rays, examinations, surgery, or any other type of investigation or treatment, please provide details here.

Type of referral, investigation or treatment	Date scheduled YYYY MM DD	Healthcare provider or facility?

3. Please describe your current condition: ☐ Recovered ☐ Improved ☐ Unchanged ☐ Deteriorating

4. Please list and comment on only the symptoms which affect your ability to attend classes.

Specific symptom	If applicable, please comment on location, duration, frequency and severity of this symptom.

E RETURN TO SCHOOL PLANS

1. Have you returned to college or university part-time? ☐ Yes ☐ No If yes, when? YYYY MM DD _____

2. Have you returned full-time? ☐ Yes ☐ No If yes, when? YYYY MM DD _____

3. If you have not returned what are your current thoughts about your readiness to do so?

☐ I do not anticipate returning on either a part-time or full-time basis.

☐ I anticipate returning part-time on or around this date: YYYY MM DD _____

☐ I anticipate returning full-time on or around this date: YYYY MM DD _____

F COMMENTS

Is there any other information you wish to add that will give us a better understanding of your condition? _____

G PERSONAL INFORMATION MANAGEMENT

Desjardins Financial Security Life Assurance Company, hereinafter 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

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 and 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 STUDENTCARE 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 student: _____ **Date:** _____

VERY IMPORTANT	**PLEASE HAVE THE "PHYSICIAN STATEMENT" FORM (NO. 12194E) FILLED OUT AND FORWARD COMPLETED FORMS TO: DESJARDINS INSURANCE, C. P. 3950, LÉVIS (QUÉBEC) G6V 8C6**

PRINT **NEW REQUEST**