

CLAIM FOR HEALTH CARE BENEFITS

TO EXPEDITE PROCESSING OF YOUR CLAIM, PLEASE ANSWER ALL QUESTIONS.

(Missing or inaccurate information may result in handling delays, and the form may be returned to you for correction.)

A Group No. <div style="text-align: center; font-weight: bold; font-size: 1.2em;">Q838</div>	Student Identification No.
Member's last name and first name	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Date of birth YYYY MM DD	
Number, street, apartment	
City, province	Postal code
Group name Concordia Graduate Students' Association	

B Is the claim the result of: • a work injury? <input type="checkbox"/> Yes <input type="checkbox"/> No • a motor vehicle accident? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes: <ul style="list-style-type: none"> • Please note that the claim must first be submitted under your provincial workers' compensation plan or automobile insurance plan (if applicable in your province) before being submitted to your group plan. • Name of injured person: _____ 	Date of accident: YYYY MM DD
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C COORDINATION OF BENEFITS - This section MUST BE COMPLETED if claiming for you, a spouse or child. The coordination of benefits may entitle you to a reimbursement of up to 100% of your expenses. HOW TO SUBMIT A CLAIM WHEN THERE ARE TWO INSURERS 1. Your spouse must first submit his or her claim to his or her own insurer and provide Desjardins Financial Security with the explanation of benefits paid by their plan including copies of the receipts. 2. Claims for dependent children must first be submitted under the plan of the parent whose birthday (month and day) comes first in the calendar year.
Is your spouse insured under another insurance contract that provides benefits for: • drugs: <input type="checkbox"/> Yes <input type="checkbox"/> No • paramedical services: <input type="checkbox"/> Yes <input type="checkbox"/> No • vision care: <input type="checkbox"/> Yes <input type="checkbox"/> No • travel: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, is the coverage: <input type="checkbox"/> Individual <input type="checkbox"/> Couple <input type="checkbox"/> Single-parent <input type="checkbox"/> Family Effective date: _____ Full name of spouse: _____ Date of birth: _____ Termination date: _____ Name of insurer: _____ Policy No.: _____ Certificate No.: _____

D PATIENT INFORMATION for the period in which expenses were incurred (use one line per patient). I confirm that the persons designated below fit the definition of spouse and dependent child as specified in the contract under which this claim has been submitted.	CHILDREN AGED 21 OR OLDER If your child has a functional impairment, please provide us with a medical certificate confirming your child's disability.																												
<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:20%;">Last name</th> <th style="width:20%;">First name</th> <th style="width:15%;">Relationship</th> <th style="width:5%;">Sex</th> <th style="width:15%;">Date of birth</th> <th style="width:25%;">Full-time student or with a functional impairment</th> <th style="width:20%;">Name of educational institution attended</th> </tr> </thead> <tbody> <tr> <td></td> <td></td> <td> <input type="checkbox"/> Member <input type="checkbox"/> Spouse <input type="checkbox"/> Child </td> <td> <input type="checkbox"/> M <input type="checkbox"/> F </td> <td> YYYY MM DD </td> <td> <input type="checkbox"/> F. time Stud. <input type="checkbox"/> Funct. Imp. From _____ To _____ </td> <td></td> </tr> <tr> <td></td> <td></td> <td> <input type="checkbox"/> Member <input type="checkbox"/> Spouse <input type="checkbox"/> Child </td> <td> <input type="checkbox"/> M <input type="checkbox"/> F </td> <td> YYYY MM DD </td> <td> <input type="checkbox"/> F. time Stud. <input type="checkbox"/> Funct. Imp. From _____ To _____ </td> <td></td> </tr> <tr> <td></td> <td></td> <td> <input type="checkbox"/> Member <input type="checkbox"/> Spouse <input type="checkbox"/> Child </td> <td> <input type="checkbox"/> M <input type="checkbox"/> F </td> <td> YYYY MM DD </td> <td> <input type="checkbox"/> F. time Stud. <input type="checkbox"/> Funct. Imp. From _____ To _____ </td> <td></td> </tr> </tbody> </table>	Last name	First name	Relationship	Sex	Date of birth	Full-time student or with a functional impairment	Name of educational institution attended			<input type="checkbox"/> Member <input type="checkbox"/> Spouse <input type="checkbox"/> Child	<input type="checkbox"/> M <input type="checkbox"/> F	YYYY MM DD	<input type="checkbox"/> F. time Stud. <input type="checkbox"/> Funct. Imp. From _____ To _____				<input type="checkbox"/> Member <input type="checkbox"/> Spouse <input type="checkbox"/> Child	<input type="checkbox"/> M <input type="checkbox"/> F	YYYY MM DD	<input type="checkbox"/> F. time Stud. <input type="checkbox"/> Funct. Imp. From _____ To _____				<input type="checkbox"/> Member <input type="checkbox"/> Spouse <input type="checkbox"/> Child	<input type="checkbox"/> M <input type="checkbox"/> F	YYYY MM DD	<input type="checkbox"/> F. time Stud. <input type="checkbox"/> Funct. Imp. From _____ To _____		
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E DIRECT DEPOSIT AND ELECTRONIC NOTICE SERVICE • 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: _____ • For more details on this service or to make changes to it, please visit our Web site at www.dfsgroupinsurance.com .
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