Desjardins Insurance
Life • Health • Retirement

Instructions – Claim for Care Received While Travelling

Travel Insurance

Submit your claim in 3 steps

Step 1 – Collect the required documents listed below.

Step 2 – Fill out and sign the Claim for Care Received While Travelling form and the provincial claim form, both attached.

Step 3 – Send us the forms and documents online or by mail:

Online
www.desjardinslifeinsurance.com/send

Mail
Desjardins Insurance
200, rue des Commandeurs
Lévis (Québec) G6V 6R2

Questions?

Call us at 1-855-368-6924

Required documents

Claim for Care Received While Travelling form.

Provincial claim form.

You must fill out this form if you want us to process your claim, even if you didn't pay any invoices. This form allows us to submit your eligible invoices for reimbursement to your governmental plan.

Original invoices for all fees incurred (for example, medical consultation or prescription fees). Please keep a copy for your records.

If you paid with your credit card, provide a copy of your account statement, as well. Otherwise, we'll calculate the reimbursement amount based on the exchange rate at the time we process your claim.

A void cheque if you want to receive your payment by direct deposit. Direct deposits can only be made to the contract owner's account.

A written confirmation from your dentist in your home province if your claim is for an injury caused by a direct, accidental blow to the mouth. They must attest that the tooth was natural and healthy before the accident.

Proof that your child was a full-time student at a recognized educational institution on the travel dates, if your claim is for a dependent child age 18 to 25. Eligible ages may vary, however. Please see your insurance contract.

To avoid delays

Make sure to fill out everything on the required forms and send us all the requested documents

If we need to return a form to you or ask for missing documents, it will take longer to process your claim.

If you can't attach all the requested documents

Please explain why on a separate sheet of paper and attach it to your claim.

ⓘ Note that we may require additional documents or information.

Protect your credit card number

Never include your credit card number in your emails or other non-secure methods of electronic communication.

Collection or transfer of your personal information outside of Canada

Desjardins Insurance uses service providers located outside of Canada to perform certain specific activities in its normal course of business. As such, personal information may be collected in and/or transferred to another country and be subject to the laws of that country.

For information about our policies and practices regarding the collection and transfer of personal information outside of Canada, see Desjardins Group's Privacy Policy at www.desjardins.com/privacy-policy. You can also obtain this information, or ask any questions you might have, by calling us a 1-800-463-7870.

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Claim for Care Received While Travelling
Travel Insurance

A. About you (the person making the claim)

Last name	First name
10-digit daytime phone number Extension:	Email address (in case we need to contact you about your claim)

B. About the person who received the care

ⓘ If more than one person received care, please complete a separate form for each person.

Who received the care you're making a claim for?

☐ Yourself →	Date of birth (YYYY-MM-DD)	Address – No., street, apt.	City	Prov./Terr.	Postal code

☐ Someone else →	Last name	First name	Date of birth (YYYY-MM-DD)	Relationship to you	
	Address – No., street, apt.		City	Prov./Terr.	Code postal

C. Coverage of the person who received the care

1. Coverage through Desjardins

Check the type or types of coverage **the person who received the care** has through Desjardins and provide the requested information.

☐ Travel insurance included with a credit card →	Credit card number

☐ Travel insurance included in a group insurance plan offered by an employer or other association →	Group number	Certificate number

☐ Other travel insurance →	Contract or policy number

2. Coverage through another insurer

Does the person who received the care (either you or someone else) have other travel insurance? ☐ Yes ☐ No

If yes, check the type or types of coverage and provide the requested information.

☐ Travel insurance included with a credit card →	Name of insurer or credit card issuer	Did you make a claim? ☐ Yes ☐ No

☐ Travel insurance included in a group insurance plan offered by an employer or other association →	Name of insurer	Group number	Certificate number	Did you make a claim? ☐ Yes ☐ No

☐ Other travel insurance →	Name of insurer	Contract number	Did you make a claim? ☐ Yes ☐ No

D. Trip details

Left home province or territory on (YYYY-MM-DD)	Initially scheduled to return to home province or territory on (YYYY-MM-DD)	Returned to home province or territory on (if different from initially scheduled date) (YYYY-MM-DD)

Where care was provided City	Country	Reason for trip
		☐ Pleasure ☐ Business ☐ To receive care ☐ Other: _____

⚠ Please sign the last page of this form

Desjardins Insurance refers to Desjardins Financial Security Life Assurance Company.

E. Reasons for receiving care

Why was the care provided? (Use a separate sheet, if needed.)

Did you contact the Assistance Service? ☐ No | ☐ Yes → File number: _____

F. Fees incurred for care

ⓘ If you didn't receive any invoices, go to section G.

Fill out the following table for each invoice received. Use a separate sheet if there are more than 3 invoices.

Invoice 1		**Type of service** (consultation, hospitalization, prescription, etc.)
Amount on invoice	Currency	

Did you pay the invoice? ☐ No | ☐ Yes → ☐ In full ☐ Partially Amount paid: _____ Currency: _____

Invoice 2		**Type of service** (consultation, hospitalization, prescription, etc.)
Amount on invoice	Currency	

Did you pay the invoice? ☐ No | ☐ Yes → ☐ In full ☐ Partially Amount paid: _____ Currency: _____

Invoice 3		**Type of service** (consultation, hospitalization, prescription, etc.)
Amount on invoice	Currency	

Did you pay the invoice? ☐ No | ☐ Yes → ☐ In full ☐ Partially Amount paid: _____ Currency: _____

G. Consent related to the management of your personal information by Desjardins Insurance

This consent applies only to the person who received the care.

1. Why Desjardins Insurance needs your consent

Your consent allows us to collect, use and disclose the personal information we require to:

1. Analyze your insurance applications
2. Manage your file while you're covered under the insurance
3. Process claims

Your consent also allows us to do the following, as required:

- Look at information in any old insurance file you may have with Desjardins Insurance
- Ask a personal information broker to provide us with an investigation report about you, if necessary
- Send a summary of your personal information, including health-related information, to MIB, LLC (see text box below), after analyzing an insurance application you've submitted

  MIB, LLC is an organization that operates a database allowing insurance companies in Canada and the United States to collect and disclose information about their clients.
- Send your doctor any medical information that we obtained about you when analyzing your insurance applications or claims, so they can share it with you
- Provide insurers and reinsurers with any relevant information (medical test results, etc.), so they can assess an insurance application you've submitted

By giving your consent to us, you also authorize our reinsurers and our subsidiary Assistel to collect, use and disclose your personal information the same way we would. Our reinsurers are companies that insure us, Desjardins Insurance.

⚠ Please sign the last page of this form

2.	**Who your personal information will be collected from or disclosed to**	You give your consent for the collection and disclosure of the necessary information with you, but also with other people and organizations. These people and organizations include: • Travel agencies, travel wholesalers, airlines • MIB, LLC • Healthcare professionals or establishments (doctors, hospitals, clinics, etc.) • Healthcare providers • Paramedical firms • Public or parapublic organizations • Insurance companies other than Desjardins Insurance • Reinsurers • Your employer or a former employer • The policyowner (also called policyholder or contract holder), if you aren't that person • Other Desjardins components, if they're involved in the insurance • A personal information broker or an investigation firm
3.	**If the request concerns someone other than yourself**	**For a minor child** You also authorize us to collect, use and disclose the necessary personal information about them, if they're under age 14 (Quebec) or under age 16 (all other provinces and territories) **For a deceased person** You also authorize us to collect, use and disclose the necessary personal information about them.

By signing this form, you:

- Authorize Desjardins Insurance, its reinsurers and its subsidiary Assistel to collect, use and disclose your personal information based on the conditions outlined in this section, the applicable regulations and Desjardins Group's Privacy Policy. You can consult the policy at www.desjardins.com/privacy-policy

H. Declaration

By signing this form, you:

- Declare that the information provided in this form and in any other document submitted for your claim is accurate and complete
- Understand that your insurance may be declared null and void or your claims may be denied if you provide false or incomplete information, or you make false statements

I. Signatures

X _____ _____

Signature of the person making the claim — Date (YYYY-MM-DD)

X _____ _____

Signature of the person who received the care — Date (YYYY-MM-DD)

› If the person is a minor child who is under age 14 (Quebec) or under age 16 (all other provinces and territories), a parent, guardian or legal representative must sign for them and complete the green box below

› If the person who received the care is deceased, please check this box ☐

Person signing for the minor child:

_____

First and last names (please print)

Relationship to the minor child:

☐ Parent (father or mother) ☐ Guardian (Quebec)

☐ Legal representative (all provinces and territories other than Quebec)

ⓘ **Make sure you've completed all the required sections.**
If any signatures or information are missing, your claim may take longer to process.

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Authorization and Release
Travel Insurance

Claim number	Date of birth of patient (YYYY-MM-DD)
Policy number	Dates of travel (YYYY-MM-DD) from: to:

1. Direction and release

I _____ irrevocably direct and authorize the Ontario Ministry of Health and Long-Term Care (the Ministry) to make payment in respect of my claim for out-of-country health services to Desjardins Insurance directly and I hereby release the Ministry, upon payment to Desjardins Insurance from any further claim or cause of action in connection therewith.

2. Consent

If providing consent for self:

I authorize the Ministry to collect my personal health information, consisting of:

- information relating to my receipt of health care services outside of Canada; and
- information relevant to the reimbursement of those services under the Health Insurance Act, R.S.O. 1990, c. H. 6;

from Desjardins Insurance, and authorize the Ministry to disclose such personal health information as may be required for the purpose of verifying my request for payment under the Health Insurance Act, including the details of any duplicate payment previously made to me, to Desjardins Insurance.

I understand the purpose for the Ministry's collection and disclosure of this personal health information.

I understand that I can refuse to sign this consent form.

Note: A substitute decision-maker is a person authorized under PHIPA to consent, on behalf of an individual, to disclose personal health information about the individual.

X_____ _____

Signature of patient (16 years of age or over) OR signature of person signing on behalf of patient (if patient is under 16 years of age)

Date (YYYY-MM-DD)

Health insurance card number of person who received the medical services **Version code**

Print Reset