 If you have any questions, please call us at 1-866-850-7198.

Instructions for filing a claim

- > Please use this form to file a claim. It must be completed by the insured person and the policyholder (if other than the insured person). An authorized representative of the insured person may also complete the claim if the latter is incapable of doing so.
- > If you are acting as the authorized representative of the insured and you file a claim on his or her behalf, please provide the document giving you the legal authorization to do so (e.g., power of attorney, documents pertaining to a guardianship or mandate in case of incapacity).
- > Be sure to complete all of the pages of this form and sign the “Authorization to collect and communicate personal information”.
- > Complete the “Identification of the insured person” section of the Attending Physician’s Statement, and have your attending physician or the physician who is most familiar with your current health condition complete both pages of this section.
- > Please provide us with a copy of your attending physician’s medical records and any other information from healthcare professionals (such as a social worker or practical nurse) with a licence to practise in Canada or the United States.
- > When all of the sections of this form have been completed and signed, please return it to us at the following address:

Desjardins Insurance
Case postale 3800
Lévis (Québec) G6V 0S1

Name of the person filing the claim (if other than the insured person)

Relationship with the insured person

10-digit phone number

A. Identification of the insured person

Last name	First name	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Policy number
Address – No., street, apt.		City	
Province	Postal code	10-digit phone number	Date of birth (YYYY-MM-DD)

B. Place of residence

Do you currently live at the address above? Yes No

If yes, who lives with you? alone spouse family member other

If no, where do you live at present? in a care facility in a hospital at a family member's home other

C. Power of attorney and guardianship

Have you given a power of attorney or are you subject to a guardianship? Yes (please provide a copy of the related documents) No

Name of the person holding the power of attorney or the legal guardian

Address – No., street, apt.

City	Province	Postal code
10-digit phone numbers	Home	Work
		Ext.



D. Care

Describe the physical impairment that triggered your loss of independence, its causes and the date you first requested assistance for this impairment.

Please provide the names of all of the physicians you consulted regarding this health problem:

Name	Address	10-digit phone number	Date last consulted (YYYY-MM-DD)

Instructions

-  The insured person or his/her authorized representative must complete this page before giving all of the necessary forms to the physician.
-  The insured person is responsible for the securing of this form and any charge which may be made for its completion.

Identification of the patient

Last name of the insured person		First name	Policy number
Address – No., street, apt.			
City		Province	Postal code
10-digit phone number		Date of birth (YYYY-MM-DD)	

Physician's instructions

Please provide complete and accurate answers to all of the questions and return the form to the patient. This medical information will be used to assess the patient's eligibility for long-term care benefits.

i Fees charged for this statement are to be paid by the insured person.

A. Identification of the insured person

Last name of the insured person	First name	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Date of birth (YYYY-MM-DD)	Policy number	

B. State of health

1. What health problems have been diagnosed for the insured person?

Principal diagnosis: _____ Onset of symptoms (YYYY-MM-DD): _____

Secondary diagnosis: _____ Onset of symptoms (YYYY-MM-DD): _____

Trigger for diagnosis (accident, suicide attempt, drugs, alcohol, etc.):

2. When was the patient's last visit? (YYYY-MM-DD) _____

What was the reason for his/her last visit (primary problem)? _____

C. Activities of daily living

i To the physician: Please answer questions 3, 4 and 5 based on the following definitions of activities of daily living (ADLs).

Bathing: the ability to wash oneself in a tub, shower or by sponge bath, with or without the aid of equipment.

Dressing: the ability to put on or take off garments and/or braces, artificial limbs or other surgical prosthetic devices.

Toileting: the ability to do all of the following, with or without the aid of equipment: (a) get to and from the toilet; (b) get on and off the toilet, and (c) perform associated personal hygiene.

Transferring: the ability to: get in and out of a chair (including a wheelchair) or bed. If a person can move with the help of equipment such as a cane, walker, crutches, grab bars or other support devices, then he or she will be considered able to transfer positions.

Continence: the ability to maintain control of bowel or bladder function; or, when unable to maintain such control, the ability to perform associated personal hygiene (including caring for a catheter or colostomy bag).

Eating: the ability to consume food that has already been prepared and made available, with or without adaptive utensils.

3. Please indicate the degree of assistance required by the patient to perform the ADLs described above. Tick off only one box for each of these activities to specify the patient's current capacity level.

Activities of daily living (ADLs)	The patient requires no assistance and performs the activity independently	The patient requires some assistance or supervision (close proximity) each time he/she performs the activity	The patient requires the direct physical assistance of another person to perform the activity
Bathing			
Dressing			
Toileting			
Transferring			
Continence			
Eating			

4. On what date did the patient first require some supervision or the direct physical assistance of another person to perform one of these activities? (YYYY-MM-DD)

5. Please provide any additional information regarding the patient's ability to perform these activities.

D. Cognitive impairment

i **To the physician:** Please answer questions 6, 7 and 8 based on the following definition of cognitive impairment.

Organic Cognitive Impairment: a loss of mental capacity demonstrated by a person's inability to think, perceive, reason or remember. Such impairment (a) results in the insured person's inability to care him or herself without ongoing supervision from another person; and (b) is due to a mental condition with an organic cause. Determination of cognitive impairment will be made on the basis of clinical data and valid standardized measure of such impairments.

6. Has the patient been diagnosed with a cognitive impairment? Yes No

If yes, please provide the diagnosis: _____

Date of onset of the impairment (YYYY-MM-DD): _____

Diagnostic tests performed:

1. _____

2. _____

7. Tick one of the following to specify the patient's degree of cognitive impairment:

The patient does not have any cognitive impairment as defined above.

The patient has a mild cognitive impairment.

The patient has a serious cognitive impairment; he/she requires constant supervision as well as reminders to protect his/her health and safety.

8. Please provide any additional information regarding the patient's ability to perform his/her activities.

E. Identification of physician

Name of the physician completing the form		Licence number		
Address – No., street, office		City	Province	Postal code
10-digit phone number	10-digit fax number	Indicate whether you are the patient's attending physician or a specialist <input type="checkbox"/> Attending physician <input type="checkbox"/> Specialist		

X _____
Signature of physician

Date (YYYY-MM-DD)

i **If you have any questions, please call Claims Administration at 1-866-850-7198.**