 **We are unable to assess this claim unless all questions are answered completely.**

**Please complete the following 3 steps:**

1. Attach a copy of your record of employment issued for Employment and Social Development Canada (ESDC).
2. Complete section A, read sections D and E et sign section F.
3. Have your employer complete sections B and C.  
If you are unable to reach your employer, you may fill out these sections yourself.

If you need additional information on submitting a claim, call us at the following number: **1-866-608-4746**.

Our offices are open Monday through Friday, from 8 a.m. to 5 p.m., except for statutory holidays.

**A. Identification of Insured**

Contract number

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

**B. Employer's statement**

Usual occupation

Date of employment (YYYY-MM-DD)	Last complete day worked (YYYY-MM-DD)		
<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Casual	Hours per week	<input type="checkbox"/> Permanent <input type="checkbox"/> Temporary	
<input type="checkbox"/> Seasonal (employment begins and ends at the same time each time)	Employment start time (YYYY-MM-DD)	Employment end date (YYYY-MM-DD)	

Did this insured work at least 20 remunerated hours per week, and pay the employment insurance premiums required by law during the four months preceding the last full day of work?

Yes    No   If not, specify the reasons and the periods:

Is the work stoppage for this insured due to:

- Loss of employment .....  Yes    No  
If yes, when was the injured advised? \_\_\_\_\_  
(YYYY-MM-DD)
- Voluntary resignation .....  Yes    No
- A strike or lock-out .....  Yes    No
- A fraud or an infraction of a law .....  Yes    No
- Retirement .....  Yes    No
- End of the term of a contract .....  Yes    No
- A leave that does not terminate the employment relationship (e.g.: sabbatical, pregnancy, etc.) .....  Yes    No
- Return to full-time studies .....  Yes    No

Last name of insured	First name	Date of birth (YYYY-MM-DD)
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## B. Employer's statement (cont.)

Is the insured eligible for employment insurance benefits?  Yes  No  
 If not, is the insured eligible for any other government program?  Yes  No If yes, explain the nature, name, and the effective date

## C. Identification of employer

Employer name and contact person

Name of the contact person		10-digit phone number	
		Extension:	
Address – No., street	City	Province	Postal code

X \_\_\_\_\_  
 Signature of employer Position Date (YYYY-MM-DD)

### Insured's statement and signature:

I've completed the sections B and C on my employer's behalf. I was unable to reach my employer. I declare that the answers I provided in these sections are complete and accurate.


X \_\_\_\_\_  
 Signature of Insured Date (YYYY-MM-DD)

## D. Consent related to the management of your personal information by Desjardins Group

<p><b>1. Management of your personal information</b></p>	<p>To serve you on a daily basis and meet our legal obligations, we need to collect, use and disclose information about you. For more details, see Desjardins Group's Privacy Policy at <a href="http://www.desjardins.com/privacy-policy">www.desjardins.com/privacy-policy</a>.</p> <p>You may be asked for specific consent to ensure that Desjardins Insurance can deliver or continue to deliver service. This will be done in compliance with Desjardins Group's Privacy Policy.</p> <p>Desjardins Insurance handles all your personal information confidentially. Your information will be accessed only by employees who require it to complete their tasks.</p>
<p><b>2. Your rights</b></p>	<p>You can:</p> <ul style="list-style-type: none"> <li>• See the personal information Desjardins Group has about you</li> <li>• Correct any information that's incomplete, ambiguous or not relevant</li> </ul> <p>To find out how, see Desjardins Group's Privacy Policy.</p>
<p><b>3. Collection or transfer of your personal information outside of Canada</b></p>	<p>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.</p> <p>For information about our policies and practices regarding the collection and transfer of personal information outside of Canada, see Desjardins Group's Privacy Policy. You can also obtain this information, or ask any questions you might have, by calling us a 1-800-463-7870.</p>

### By signing this form, you:

- Acknowledge that you've looked at Desjardins Group's Privacy Policy, which is available at [www.desjardins.com/privacy-policy](http://www.desjardins.com/privacy-policy)
- Authorize Desjardins Group to collect, use and disclose your personal information based on the conditions outlined in the policy and applicable regulations
- Acknowledge and accept that this consent takes precedence over any other consent you've previously signed
- Acknowledge that this consent remains valid for as long as you have a business relationship with a Desjardins Group component

 Please sign the last page of this form

Last name of insured	First name	Date of birth (YYYY-MM-DD)
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## E. Consent related to the information Desjardins Insurance gets about you

### 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 to collect, use and disclose your personal information the same way we would. Our reinsurers are companies that insure us, Desjardins Insurance.

### 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:

- 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 application concerns your children

You 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).

#### By signing this form, you:

- Authorize Desjardins Insurance and its reinsurers 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](http://www.desjardins.com/privacy-policy).



Please sign the next page of this form

## F. Signature



X

\_\_\_\_\_  
Signature of the insured person

\_\_\_\_\_  
Date (AAAA-MM-JJ)