Desjardins Insurance
Life • Health• Retirement

200, rue des Commandeurs
Lévis (Québec) G6V 6R2
www.desjardinslifeinsurance.com

DISABILITY OR CRITICAL ILLNESS CLAIM
Insured's Statement

Desjardins Insurance refers to Desjardins Financial Security Life Assurance Company.

PRINT RESET

Identification of insured

Last name		Date of birth
First name	Contract number	Claimant number

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

General information

1. Date of first symptoms related to the current disability
YYYY - MM - DD

2. Date of first visit to a physician for this illness or injury
(YYYY-MM-DD)

3. Was this an accident? ☐ Yes ☐ No If yes, specify: Type of accident: ☐ work-related ☐ motor vehicle ☐ other

Date of accident: (YYYY-MM-DD) Specify where and how the accident occured: _____

4. In the 2 years prior to the current disability, did you consult a physician or healthcare professional or were you hospitalized?
☐ Yes ☐ No If yes, complete the following table:

Name of physicians or professionals consulted	Medical reasons	Dates of consultation	Name of hospitals where you were treated	Hospitalization periods
		(YYYY-MM-DD)		from: (YYYY-MM-DD) to: (YYYY-MM-DD)
		(YYYY-MM-DD)		from: (YYYY-MM-DD) to: (YYYY-MM-DD)
		(YYYY-MM-DD)		from: (YYYY-MM-DD) to: (YYYY-MM-DD)

5. During the 2 years prior to the current disability, did you take any medication? ☐ Yes ☐ No If yes, complete the following table:

Medical reasons	Name of medication	Periods
		from: (YYYY-MM-DD) to: (YYYY-MM-DD)
		from: (YYYY-MM-DD) to: (YYYY-MM-DD)

6. Do you have a family doctor? ☐ Yes ☐ No

If yes, specify: Doctor's name: _____ Since when: (YYYY-MM-DD)

7. Have you submitted a claim to a government organization or another company? ☐ Yes ☐ No If yes, specify:

☐ CNESST/WSIB/WCB ☐ Retraite Québec/CPPD ☐ SAAQ
☐ Insurance company Specify name: _____
☐ Other (e.g., Employment Insurance sickness benefits) Case no., contract or certificate no.: _____

8a. Are you: ☐ a salaried worker ☐ a self-employed worker
☐ other (please specify: on maternity leave, retired, unemployed, etc.): _____

8b. What is your level of education? _____

⚠ **If you're a salaried or self-employed worker, please answer the questions in the next section below.**

DECLARATION OF INSURED – I declare that the information provided above is complete and true.

Signature of insured _____ Date _____

10-digit phone number (home) _____

10-digit phone number (cell.) _____

B2E (2022-05)

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Declaration of salaried or self-employed worker

9.1 First date of service: (YYYY-MM-DD) 9.2 Last full day of work: (YYYY-MM-DD)

9.3 Job title:

9.4 Salary:

9.5 What are the main duties of the employee's job and how much time is allocated to each one weekly?

Duty	%	Duty	%

9.6 Specify the number of hours worked in each of the 4 weeks prior to the disability:

Periods		Number of hours	Explain any period of fewer than 20 hours
from: (YYYY-MM-DD)	to: (YYYY-MM-DD)		
from: (YYYY-MM-DD)	to: (YYYY-MM-DD)		
from: (YYYY-MM-DD)	to: (YYYY-MM-DD)		
from: (YYYY-MM-DD)	to: (YYYY-MM-DD)		

9.7 Have you returned to work? ☐ Yes ☐ No
On what date: _____ (YYYY-MM-DD)
Was this return to work: ☐ gradual ☐ full-time ☐ part-time ☐ a temporary assignment

9.8 Have you returned to school? ☐ Yes ☐ No
On what date: _____ (YYYY-MM-DD)
Number of class hours per week: _____

9.9.During the 2 years prior to the current disability, did you miss work due to an illness or accident?
☐ Yes ☐ No If yes, specify:

Date of absence		Reason
from: (YYYY-MM-DD)	to: (YYYY-MM-DD)	

9.10 Name of employer		10-digit phone number	10-digit fax number
Address - No., street	City	Province	Postal code
Name of contact		Title	
Email address			

DECLARATION OF SALARIED OR SELF-EMPLOYED WORKER – I declare that the information provided above is complete and true.

Signature of insured _____ Date _____