Desjardins Insurance
Life • Health • Retirement

C.P. 3400
Lévis QC G6V 0R8

INDIVIDUAL INSURANCE

Claim for loss of employment benefits

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 sections A and D.
3. Have your employer complete sections B and C
   Loss of employment due to **COVID-19**: If you're unable to reach your employer, you can fill out these 2 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.

Contract number

A. IDENTIFICATION OF INSURED

Last name of insured	First name		Date of birth YYYY-MM-DD
Address – No., street, apt.	City	Province	Postal code
Telephone number (Area code + number)	Home:		

B. EMPLOYER'S STATEMENT

Usual occupation

Date of employment YYYY-MM-DD	Last complete day worked YYYY-MM-DD
☐ Full-time ☐ Part-time ☐ Casual	Hours per week ☐ Permanent ☐ Temporary

☐ 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

Contract number

Last name of insured	First name	Date of birth
		YYYY-MM-DD

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

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C. IDENTIFICATION OF EMPLOYER

Employer name and contact person			
Name of the contact person		Telephone number (Area code + number) Extension:	
Address – No., street	City	Province	Postal Code

Signature of employer ______________________ **Position** ______________________ **Date** __________

Insured's statement and signature:

I've completed the sections above on my employer's behalf. I was unable to reach my employer due to the COVID-19 crisis. I declare that the answers I provided in these sections are complete and accurate.

Signature of Insured ______________________ **Date** __________

D. AUTHORIZATION TO COLLECT AND COMMUNICATE PERSONAL INFORMATION

For the sole purpose of determining insurability, managing files and processing claims, I authorize Desjardins Financial Security Life Assurance Company (DFS) or its reinsurers:

- to collect from any individual, legal entity or public or parapublic organization only the personal information they have about me that is needed to process my file. This information may be collected from third parties, including any health care professional or establishment, MIB, Inc., insurance and reinsurance companies, personal information brokers, investigation firms, the contract holder, my employer or my former employers;
- to disclose to those individuals, legal entities or public or parapublic organizations only the personal information they have about me that is needed to manage my file;
- to request, if applicable, an investigation report about me and to use the personal information contained in other files it may have that are now closed;
- to disclose to my personal physician any medical information about me that was obtained during the evaluation of my file;
- to disclose to other insurers or reinsurers any information about me that is relevant to determining my eligibility for insurance or for benefits;
- to provide a brief report on my personal information, including my health information, to MIB, Inc.

This authorization also applies to the collection, use and communication of personal information regarding my dependents, insofar as applicable to my claim. A photocopy of this authorization is as valid as the original.

Signature of insured ______________________ **Date** __________