Desjardins Insurance
LIFE • HEALTH • RETIREMENT

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

CLAIM
EMPLOYER'S STATEMENT

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☐ Death
☐ Critical illness
☐ Accidental dismemberment or loss of sight

We cannot settle this claim unless all questions are answered adequately.

A. Identification of employee

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

B. Identification of individual concerned (if other than the employee)

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

C. Identification of employer

Name of employer		
Address - No., Street		
City	Province	Postal code
Telephone no. Area code + number	Extension	
Contract/Group no.	Account/Division no.	Identification/Certificate no.

D. Employer's statement

1. Date of hiring YYYY-MM-DD		2. Coverage effective date YYYY-MM-DD
3. Does the employee work on a part-time basis (more than 25% and less than 75% of time)? ☐ Yes ☐ No	If so, specify the % compare to full time work %	4. Does the employee work on a full-time basis (more than 75% of time)? ☐ Yes ☐ No
5. Was the insured disabled before the event? ☐ Yes ☐ No		6. Date of beginning of disability YYYY-MM-DD
7. Last date worked YYYY-MM-DD	8. Salary at beginning of disability	9. Annual salary at the date of the event
10. If this is a death claim, would you like the payment to be sent to the employer? ☐ Yes ☐ No		
Remarks		

E. Declaration

I declare that the information provided above is complete and true.

Signature of employer's representative | **Title** | **Date**