Submit online:
desjardinslifeinsurance.com/send
Complete and save the form on your computer first.
Keep the original for your records.

By mail:
PO Box 1024 STN A
Toronto ON M5W 1G5
Send the original and keep copies for your records.

By fax:
1-855-678-8124 (toll free)
604-678-8124
Keep the original for your records.

Desjardins Insurance
Life • Health • Retirement

GROUP INSURANCE – DISABILITY CLAIMS

AUTHORIZATION

(WITH RESPECT TO THE COLLECTION, USE AND COMMUNICATION OF PERSONAL INFORMATION)

Claimant name: _____ **School district Number:** _____

Email address (please provide your email address only if you consent to this form of communication)**:** _____

I authorize Desjardins Financial Security Life Assurance Company, hereinafter Desjardins Insurance, strictly for the purpose of determining my insurability, managing my file and settling my claims to:

- collect relevant personal and health information about me from any of the following: healthcare and healthcare related professionals, facilities or organizations; the MIB (formerly known as Medical Information Bureau); the PEBT Board of Trustees; any government health insurance plan or program, insurance companies or investigation agencies;
- communicate relevant personal and health information to the said persons or organizations;
- collect relevant personal and health information about me from my employer or former employers or the policyholder; and
- communicate to Service Canada, strictly for the purposes of supporting my application to the Canada Pension Plan (CPP), any medical information, rehabilitation reports or other information necessary to determine if I qualify for CPP disability benefits.

I authorize said persons and organizations to release this information to Desjardins Insurance strictly for the purpose of obtaining the information needed to manage my file and settle my claims. To achieve the purposes described above and to provide you support, your information, on a depersonalized basis, may be used for analysis, statistics and development of predictive models.

Provided that I have entered my email address in the first section of this form, I authorize Desjardins Insurance and PEBT to contact me at that address.

A photocopy of this authorization is as valid as the original.

Name of the employee (PLEASE PRINT)	**Signature**	**Date**

For quality assurance you may receive an email survey from the Public Education Benefits Trust.

Desjardins Insurance does not share personal or health information with your employer or union, except information collected from and originating with them and where prescribed or allowed by law.

Personal Information Management
To serve you effectively every day and fulfill our legal obligations, we need to collect, use and disclose information about you. You can read Desjardins Group's Privacy Policy at www.desjardins.com/privacy-policy for full details on how your personal information is processed. Specific consents may be required to begin and maintain a business relationship with Desjardins Insurance. These steps will be taken in compliance with Desjardins Group's Privacy Policy. Desjardins Insurance handles the personal information it has on you in a confidential manner. Access to your file is limited to authorized personnel who need it to access it to perform their duties. Desjardins Insurance may also communicate with plan members to provide them with optimal health management (management claim tools, informative health documentations, etc.) and offer its clients an insurance product following the termination of their group insurance. You have the right to review your personal information in our files and correct anything that is incomplete, ambiguous or not relevant. To do so, please consult our Privacy Policy.

PRINT NEW REQUEST