Desjardins Insurance
LIFE • HEALTH • RETIREMENT

C. P. 3000
Lévis (Québec) G6V 9X8
www.desjardinslifeinsurance.com

GROUP INSURANCE - CONTRACT ADMINISTRATION

APPLICATION FOR ENROLMENT

☐ New application ☐ Reinstatement

A - IDENTIFICATION – Please print

Name of policyholder	Group number	Division number	Certificate number

Last name of member	First name	Date of birth (YYYY MM DD)	Sex	Language
			☐ M ☐ F	☐ English ☐ French

Address - No., street, apt.	City	Province	Postal code

Annual salary	Class	Date employed on a full-time basis (YYYY MM DD)	Eligibility date (YYYY MM DD)	Number of hours worked per week

Present occupation

Coverage ☐ Individual – If your plan allows, would you like to select basic life insurance for your dependents? ☐ Yes ☐ No

☐ Family ☐ Couple
☐ Single-parent

If your plan allows, when you choose one of these coverages, you will automatically have basic life insurance for your dependents.

B - REQUEST FOR EXEMPTION

If your plan allows, would you like to waive coverage under either or both of these benefits? ☐ Extended health care ☐ Dental care
To be exempt, you must already be covered under another similar group insurance plan.

C - IDENTIFICATION OF DEPENDENTS

- **Please complete this section if you selected family coverage.**
- **If you have more than four dependent children, please use another form no. 9147A or complete form no. 00291E.**
- **Note 1: Care included in Extended health care benefit**
- **Note 2: Refer to your policy for eligible age.**
- **Note 3: Please complete form no. 09296E and return it to the address shown on the form.**

SPOUSE

Last name / First name	Date of birth (YYYY MM DD)	Sex	If common-law spouse, date cohabitation began (YYYY MM DD)	Has a child been born of this union?
		☐ M ☐ F		☐ No ☐ Yes - Provide details below

OTHER INSURANCE	Covered care or benefit	Coverage	If your spouse is also insured by Desjardins Insurance
☐ No ☐ Yes - specify to the right	☐ Medical care [1] ☐ Paramedical care [1] ☐ Dental care	☐ Individual ☐ Family ☐ Single-parent ☐ Couple	Group no.: _____ Certificate no.:

DEPENDENT CHILDREN

1 Last name / First name / Date of birth (YYYY MM DD) / Sex ☐ M ☐ F

OTHER INSURANCE ☐ No ☐ Same as spouse (above) ☐ Other

IF AGE 18 OR OLDER [2] AND functional impairment,[3] please check: ☐

IF AGE 18 OR OLDER [2] AND full-time student, please specify: FROM: (YYYY MM DD) TO: (YYYY MM DD) Name of educational institution

2 Last name / First name / Date of birth (YYYY MM DD) / Sex ☐ M ☐ F

OTHER INSURANCE ☐ No ☐ Same as spouse (above) ☐ Other

IF AGE 18 OR OLDER [2] AND functional impairment,[3] please check: ☐

IF AGE 18 OR OLDER [2] AND full-time student, please specify: FROM: (YYYY MM DD) TO: (YYYY MM DD) Name of educational institution

3 Last name / First name / Date of birth (YYYY MM DD) / Sex ☐ M ☐ F

OTHER INSURANCE ☐ No ☐ Same as spouse (above) ☐ Other

IF AGE 18 OR OLDER [2] AND functional impairment,[3] please check: ☐

IF AGE 18 OR OLDER [2] AND full-time student, please specify FROM: (YYYY MM DD) TO: (YYYY MM DD) Name of educational institution

4 Last name / First name / Date of birth (YYYY MM DD) / Sex ☐ M ☐ F

OTHER INSURANCE ☐ No ☐ Same as spouse (above) ☐ Other

IF AGE 18 OR OLDER [2] AND functional impairment,[3] please check: ☐

IF AGE 18 OR OLDER [2] AND full-time student, please specify FROM: (YYYY MM DD) TO: (YYYY MM DD) Name of educational institution

PLEASE COMPLETE THE BACK OF THIS FORM.

D - OPTIONAL BENEFITS

- **Please check the provisions under your plan.**
- **For each benefit, indicate the coverage you want.**
- **You must complete the Evidence of insurability form no. 20009A if you select the Optional life benefit OR form no. 98140E if you select the Optional critical illness benefit on its own or combined with the Optional life benefit and/or the Optional AD&D benefit.**

IMPORTANT – The Evidence of insurability form (20009A or 98140E) must be received by the insurer within 45 days of your application. If the form is not received within this timeframe, your application for enrolment in the Optional life benefit or the Optional critical illness benefit will automatically be cancelled.

☐ **OPTIONAL LIFE** Have you used tobacco in any form during the last 12 months?

Member: ☐ Yes ☐ No Spouse: ☐ Yes ☐ No The insurer must be informed of any change in this status.

☐ MEMBER	☐ SPOUSE	☐ EACH CHILD
_____ No. of times the annual salary	_____ No. of times the annual salary	_____ No. of times the annual salary
OR _____ No. of units of $ _____	**OR** _____ No. of units of $ _____	**OR** _____ No. of units of $ _____
OR $ _____ Fixed amount	**OR** $ _____ Fixed amount	**OR** $ _____ Fixed amount

☐ **OPTIONAL ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D)**

☐ MEMBER	☐ SPOUSE	☐ EACH CHILD
_____ No. of times the annual salary	_____ No. of times the annual salary	_____ No. of times the annual salary
OR _____ No. of units of $ _____	**OR** _____ No. of units of $ _____	**OR** _____ No. of units of $ _____
OR $ _____ Fixed amount	**OR** $ _____ Fixed amount	**OR** $ _____ Fixed amount

☐ **OPTIONAL CRITICAL ILLNESS**

☐ MEMBER	☐ SPOUSE	☐ EACH CHILD
_____ No. of times the annual salary	_____ No. of times the annual salary	_____ No. of times the annual salary
OR _____ No. of units of $ _____	**OR** _____ No. of units of $ _____	**OR** _____ No. of units of $ _____
OR $ _____ Fixed amount	**OR** $ _____ Fixed amount	**OR** $ _____ Fixed amount

E - DESIGNATION OF BENEFICIARY(IES) – Please read sections H and I before completing this section.

Last name, first name	Relationship	%	Date of birth if minor YYYY	MM	DD	Please check
						☐ Revocable ☐ Irrevocable
						☐ Revocable ☐ Irrevocable
						☐ Revocable ☐ Irrevocable
						☐ Revocable ☐ Irrevocable

DESIGNATION OF A TRUSTEE
(Important information in section I)

For the province of Québec: The provisions of the Civil Code apply. DO NOT complete this section.
For all other provinces: Complete this section only if you have named a minor beneficiary.

Last and first names of trustee _____ Relationship _____

Address of trustee _____
No., street, apt. City Province Postal code

F - DECLARATION AND AUTHORIZATION FOR THE COLLECTION AND COMMUNICATION OF PERSONAL INFORMATION

I certify that all the information provided herein is complete and true. I acknowledge that all the benefits offered in the contract are subject to the provisions for limitations or reductions as well as to the exclusions stipulated therein. I acknowledge that I have read and received a copy of the Personal Information Management section at the back of this form. In the event of death, I expressly authorize my beneficiary(ies), heir(s) or estate liquidator(s) to provide Desjardins Financial Security Life Assurance Company or its reinsurers with all the information or authorizations deemed necessary to study the claim and obtain the required proofs. This authorization also applies to my minor children, insofar as applicable to this claim. I authorize my employer to deduct the required premium contributions from my salary. A photocopy of this authorization is as valid as the original.

Signature of member **Signature of authorized person** **Date**

PLAN ADMINISTERED THROUGH THE SECURE SITE FOR PLAN ADMINISTRATORS

Please keep the original and give a copy to the member.

PLAN ADMINISTERED BY THE INSURER

Please send the original to Desjardins Financial Security Life Assurance Company and give a copy to the member.

G - PERSONAL INFORMATION MANAGEMENT

Desjardins Financial Security Life Assurance Company (DFS) handles the personal information it has on you in a confidential manner. DFS keeps this information on file so that you may benefit from group insurance services offered by the Company. This information is consulted solely by DFS employees who need to do so in the course of their work. You have the right to consult your file. You may also have information corrected if you demonstrate that it is inaccurate, incomplete, ambiguous or not useful. To do so, you must send a written request to the following address: Privacy Officer, Desjardins Financial Security Life Assurance Company, 200, rue des Commandeurs, Lévis, Québec, G6V 6R2. DFS may use the client list to offer its clients an insurance product following the termination of their group insurance. If you do not wish to receive these offers, you may have your name removed from the list. To do so, you must send a written request to the Privacy Officer at DFS.

H - DESIGNATION OF BENEFICIARY(IES)

For the province of Québec: Unless otherwise stipulated, the designation of a legal spouse or spouses joined in a civil union as beneficiary is IRREVOCABLE. Unless otherwise stipulated, the designation of any other person as beneficiary is REVOCABLE.

For all other provinces: This designation of beneficiary is REVOCABLE unless otherwise stipulated.

REVOCABLE: means that the designation of beneficiary can be changed without the beneficiary's consent.

IRREVOCABLE: means that the signature of the irrevocable beneficiary is mandatory to change the beneficiary. The IRREVOCABLE designation of a minor cannot be changed until they reach the age of majority.

I - DESIGNATION OF A TRUSTEE – Does not apply in Québec

The trustee designated on the reverse will receive in trust for a minor beneficiary any amount under the plan established by Desjardins Financial Security Life Assurance Company. Receipt of these funds by the trustee constitutes a discharge for Desjardins Financial Security Life Assurance Company. A designation is valid until a new trustee is named or until the beneficiary will have reached the age of majority, whichever occurs first.

PRINT RESET