Desjardins Insurance
LIFE • HEALTH • RETIREMENT

Desjardins Insurance refers to Desjardins Financial Security Life Assurance Company.

C. P. 3000
Lévis (Québec) G6V 9X8

GROUP INSURANCE - CONTRACT ADMINISTRATION

MEMBER'S CHANGE REQUEST

To ensure approval of adequate coverage, please submit all changes within 31 days of the insurance eligibility date. To change a beneficiary, please use form no. 20007A.

A - IDENTIFICATION – Please print

Name of policyholder	Group number	Division number

Last name of member	First name	Certificate number

B - CHANGE OF COVERAGE – Please complete sections C1 or C2, if applicable

B1 – Coverage requested

☐ Individual WITHOUT dependent life insurance
☐ Individual WITH dependent life insurance – **If offered under your policy.**
☐ Single-parent ☐ Family ☐ Couple

B2 – Event

☐ marriage or civil union
☐ termination of the other insurance
☐ other, specify:
☐ birth or adoption
☐ start of common-law relationship
Has a child been born of this union? ☐ Yes ☐ No
Please add this child in section C1

Date of the event: YYYY MM DD

C1 - IDENTIFICATION OF DEPENDENTS – Complete if you selected single-parent, family or couple coverage

SPOUSE
Last name
First name
Date of birth: YYYY MM DD
Sex: ☐ M ☐ F
Date of: ☐ marriage ☐ beginning of cohabitation → YYYY MM DD
Has a child been born of this union? ☐ No ☐ Yes - Provide details below

OTHER INSURANCE: ☐ No ☐ Yes - specify to the right
Covered care or benefit: ☐ Medical care [1] ☐ Paramedical care [1] ☐ Dental care
Coverage: ☐ Individual ☐ Family ☐ Single-parent ☐ Couple
Coverage period: YYYY MM DD — FROM: — TO:
If other insurance through DFS: Group no.: — Certificate no.:

1 - DEPENDENT CHILD
Last name
First name
Date of birth: YYYY MM DD
Sex: ☐ M ☐ F
IF AGE 18 OR OLDER [2]: ☐ Full-time student ☐ Functional impairment
FROM: YYYY MM DD — TO: YYYY MM DD
Name of educational institution:

OTHER INSURANCE: ☐ No ☐ Same as spouse (above) ☐ Other - specify to the right
Date of birth of holder of other insurance: YYYY MM DD
Covered care or benefit: ☐ Medical care [1] ☐ Paramedical care [1] ☐ Dental care
☐ Individual ☐ Family ☐ Single-parent ☐ Couple
Coverage period: YYYY MM DD — FROM: — TO:
If other insurance through DFS: Group no.: — Certificate no.:

2 - DEPENDENT CHILD
Last name
First name
Date of birth: YYYY MM DD
Sex: ☐ M ☐ F
IF AGE 18 OR OLDER [2]: ☐ Full-time student ☐ Functional impairment
FROM: YYYY MM DD — TO: YYYY MM DD
Name of educational institution:

OTHER INSURANCE: ☐ No ☐ Same as spouse (above) ☐ Other - specify to the right
Date of birth of holder of other insurance: YYYY MM DD
Covered care or benefit: ☐ Medical care [1] ☐ Paramedical care [1] ☐ Dental care
☐ Individual ☐ Family ☐ Single-parent ☐ Couple
Coverage period: YYYY MM DD — FROM: — TO:
If other insurance through DFS: Group no.: — Certificate no.:

[1] **Care included in Extended health care benefit** [2] **Refer to your policy for eligible age**

C2 - DELETION OF DEPENDENTS – Please complete section B1 if you would like to change your coverage

I no longer want my plan to cover the following dependents:
Effective date: YYYY MM DD
Last name, first name:
Last name, first name:

D - REQUEST FOR EXEMPTION OR TERMINATION OF EXEMPTION

EXEMPTION
If my plan allows, I waive coverage under this(these) benefit(s) since I am already covered under another similar group insurance plan: ☐ extended health care ☐ dental care.
Date of the event: YYYY MM DD

TERMINATION OF EXEMPTION
As I am no longer covered by another similar group insurance plan, I wish to be covered again under this(these) benefit(s): ☐ extended health care ☐ dental care.
Date of the event: YYYY MM DD

Coverage requested:
☐ Individual WITHOUT dependent life insurance
☐ Individual WITH dependent life insurance – **If offered under your policy.**
☐ Single-parent ☐ Family ☐ Couple

E - OPTIONAL BENEFITS – You must complete the insurability report no. 20009A if you select the optional life benefit OR use form no. 98140E if you select critical illness benefit on its own or combined with one or two other benefits. Complete only one section: A, B or C.

	☐ OPTIONAL LIFE **Enter the total amount requested**	☐ ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) **Enter the total amount requested**	☐ CRITICAL ILLNESS **Enter the total amount requested**
A	☐ MEMBER No. ____ times the annual salary	☐ MEMBER No. ____ times the annual salary	☐ MEMBER No. ____ times the annual salary
B	☐ MEMBER No. ____ $ _____ unit ☐ SPOUSE ____ $ _____ unit	☐ MEMBER No. ____ $ _____ unit ☐ SPOUSE ____ $ _____ unit	☐ MEMBER No. ____ $ _____ unit ☐ SPOUSE ____ $ _____ unit
C	☐ MEMBER Fixed amount of $ _____ ☐ SPOUSE Fixed amount of $ _____ ☐ EACH CHILD Fixed amount of $ _____	☐ MEMBER Fixed amount of $ _____ ☐ SPOUSE Fixed amount of $ _____ ☐ EACH CHILD Fixed amount of $ _____	☐ MEMBER Fixed amount of $ _____ ☐ SPOUSE Fixed amount of $ _____ ☐ EACH CHILD Fixed amount of $ _____

F - CANCELLATION OF OPTIONAL BENEFITS

I am cancelling the following optional benefit(s):

☐ Optional life:	☐ member	☐ spouse	☐ dependent children	☐ dependents (spouse and children)
☐ Accidental death and dismemberment:	☐ member	☐ spouse	☐ dependent children	☐ dependents (spouse and children)
☐ Critical illness:	☐ member	☐ spouse	☐ dependent children	☐ dependents (spouse and children)

G - ☐ MATERNITY LEAVE ☐ PARENTAL LEAVE ☐ TEMPORARY LAYOFF ☐ UNPAID LEAVE

Please check the provisions provided under your plan

I wish to:
☐ keep the benefits provided by my group insurance plan.
☐ cancel all benefits under my group insurance plan.
excluding the one that includes prescription drug coverage (Québec only).
☐ cancel the disability income insurance under my group insurance plan.

Date of beginning of leave: YYYY MM DD
Expected return to work date:

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

WHITE - Desjardins Financial Security Life Assurance Company YELLOW - Policyholder PINK - Member

04035E (13-03) **ELECTRONIC VERSION - Please return the original to Desjardins Financial Security Life Assurance Company and give a copy to the member.**

Print Reset