



FINANCIAL SERVICES INCLUDING INSURANCE,
ANNUITIES, CREDIT AND RELATED SERVICES

Please check: **New Application**
or **Reinstatement**

IDENTIFICATION - Please print clearly in ink. Card will be returned if not fully completed.

Name of policyholder		Contract/Group No.	Division/Account No.	Certificate No.
Participant's last name		First name		Social Insurance No.
Address		Sex <input type="checkbox"/> M <input type="checkbox"/> F	Language <input type="checkbox"/> English <input type="checkbox"/> French	Date of birth MM DD YY
City	Province	Postal Code	Class	Gross annual salary \$
Occupation	Date employed on a full time basis MM DD YY		Number of hours worked per week	
Marital status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Common-law spouse		Requested coverage <input type="checkbox"/> Individual <input type="checkbox"/> Family <input type="checkbox"/> Single parent <input type="checkbox"/> Couple		
If my plan allows, I waive coverage under this benefit since I am already covered under my spouse's plan. <input type="checkbox"/> Health Insurance <input type="checkbox"/> Dental Care				
When a policy is reinstated , include a copy of the spouse's former certificate.				

INFORMATION ON DEPENDENTS - Complete if you selected family, couple or single parent coverage.

Last name, first name	Sex M - F	Relationship with participant Complete if not the legal spouse, a legally adopted or natural child.	Date of birth MM DD YY	Dependent's status S = Student College/ University X = Disabled	Covered under another plan: Health Dental care Yes / No Yes / No
Spouse			MM DD YY		
Child			MM DD YY		
Child			MM DD YY		
Child			MM DD YY		

OPTIONAL BENEFITS

If your contract allows these benefits, please complete the form 20-009A "Evidence of insurability".

<input type="checkbox"/> OPTIONAL LIFE INSURANCE	<input type="checkbox"/> ACCIDENTAL DEATH AND DISMEMBERMENT	<input type="checkbox"/> CRITICAL ILLNESS
Sum insured requested: ① _____ Times the annual salary <input type="checkbox"/> participant <input type="checkbox"/> spouse or ② _____ \$ _____ Segment <input type="checkbox"/> participant <input type="checkbox"/> spouse or ③ Fixed amount of \$ _____ <input type="checkbox"/> participant Fixed amount of \$ _____ <input type="checkbox"/> spouse Fixed amount of \$ _____ <input type="checkbox"/> each child	Sum insured requested: ① _____ Times the annual salary <input type="checkbox"/> participant <input type="checkbox"/> spouse or ② _____ \$ _____ Segment <input type="checkbox"/> participant <input type="checkbox"/> spouse or ③ Fixed amount of \$ _____ <input type="checkbox"/> participant <input type="checkbox"/> spouse Fixed amount of \$ _____ <input type="checkbox"/> each child	Sum insured requested: ① _____ Times the annual salary <input type="checkbox"/> participant <input type="checkbox"/> spouse or ② _____ \$ _____ Segment <input type="checkbox"/> participant <input type="checkbox"/> spouse or ③ Fixed amount of \$ _____ <input type="checkbox"/> participant <input type="checkbox"/> spouse Fixed amount of \$ _____ <input type="checkbox"/> each child

BENEFICIARY(IES) DESIGNATION

Last name, first name	Relationship	Please check (See on reverse) <input type="checkbox"/> Revocable <input type="checkbox"/> Irrevocable
		<input type="checkbox"/> Revocable <input type="checkbox"/> Irrevocable

DECLARATION AND AUTHORIZATION FOR THE COLLECTION AND COMMUNICATION OF PERSONAL INFORMATION

I acknowledge having read the above information. I acknowledge that the benefits offered are subject to the limitation and/or reduction clauses, as well as to the exclusions stipulated in the contract. I acknowledge that I have read the notice regarding the opening of a personal information file and that I have received a copy thereof. 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 necessary contribution from my salary and I authorize Desjardins Financial Security Life Assurance Company to use or communicate my social insurance number for administrative purposes. A photocopy of this authorization is as valid as the original.

SIGNATURE
OF PARTICIPANT

SIGNATURE OF EMPLOYER'S
REPRESENTATIVE

DATE

WHITE: Desjardins Financial Security Life Assurance Company - YELLOW: Employer - PINK: Participant

PURPOSE OF THE APPLICATION FOR GROUP INSURANCE

The purpose of the application for group insurance is to provide written confirmation of your wish to obtain coverage under the group insurance contract held by the policyholder. The information requested will be used to determine your coverage and your premium.

NOTICE REGARDING THE OPENING OF A PERSONAL INFORMATION FILE

All personal information that Desjardins Financial Security Life Assurance Company has or will have regarding you will be kept confidential in **a file opened for the purpose of offering you insurance, annuities, credit and other related financial services**. Access to your file will be restricted to employees of Desjardins Financial Security Life Assurance Company who must consult it in the course of their duties.

You may access your file and ask that the information it contains be corrected, provided you can demonstrate that this information is inaccurate, incomplete, ambiguous, out-of-date or unnecessary. You may consult your file on written request to the person in charge of protection of personal information at Desjardins Financial Security Life Assurance Company, 200 avenue des Commandeurs, Lévis, Québec, G6V 6R2.

BENEFICIARY(IES) DESIGNATION

REVOCABLE: Means that the designation of beneficiary can be changed without his/her consent.

IRREVOCABLE: Means that the signature of the irrevocable beneficiary is mandatory upon a change of beneficiary.