

APPLICATION FOR ENROLMENT

Please check: New application
or Reinstatement

A - IDENTIFICATION – Please print

Name of policyholder		Group No.	Division No.	Certificate No.
Last name of member	First name	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth YY MM DD	Social insurance No.
Address - No., street, apt.		City	Province	Postal code
Present occupation	Annual salary	Class	Date employed on a full-time basis YY MM DD	Date of permanent status YY MM DD
			Number of hours worked per week	Language <input type="checkbox"/> English <input type="checkbox"/> French
Coverage: <input type="checkbox"/> Individual <input type="checkbox"/> Single parent <input type="checkbox"/> Family <input type="checkbox"/> Couple				

B - REQUEST FOR EXEMPTION

If my plan allows, I waive coverage under this(these) benefit(s): health insurance dental care since I am already covered under my spouse's plan.

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

Last name, first name	Sex M - F	Relationship with member (spouse, child)	Date of birth			Dependent's status S = 21 to 25 years, full-time student X = Disabled	Covered under another plan	
			YY	MM	DD		Health Yes / No	Dental care Yes / No

D - OPTIONAL BENEFITS – Please check the provisions provided under your plan.

You must complete an insurability report. Please use form No. 20009A if you select Optional life insurance or Accidental death and dismemberment insurance. Use form No. 98140E if you select Critical illness on its own or combined with one or two other benefits.

<input type="checkbox"/> OPTIONAL LIFE INSURANCE Complete only one section: A, B or C	<input type="checkbox"/> ACCIDENTAL DEATH AND DISMEMBERMENT Complete only one section: A, B or C	<input type="checkbox"/> CRITICAL ILLNESS Complete only one section: A, B or C
A <input type="checkbox"/> MEMBER _____ times the annual salary Nb	A <input type="checkbox"/> MEMBER _____ times the annual salary Nb	A <input type="checkbox"/> MEMBER _____ times the annual salary Nb
B <input type="checkbox"/> MEMBER _____ \$ _____ segment Nb <input type="checkbox"/> SPOUSE _____ \$ _____ segment Nb	B <input type="checkbox"/> MEMBER _____ \$ _____ segment Nb <input type="checkbox"/> SPOUSE _____ \$ _____ segment Nb	B <input type="checkbox"/> MEMBER _____ \$ _____ segment Nb <input type="checkbox"/> SPOUSE _____ \$ _____ segment Nb
C <input type="checkbox"/> MEMBER Fixed amount of \$ _____ <input type="checkbox"/> SPOUSE Fixed amount of \$ _____ <input type="checkbox"/> EACH CHILD Fixed amount of \$ _____	C <input type="checkbox"/> MEMBER Fixed amount of \$ _____ <input type="checkbox"/> SPOUSE Fixed amount of \$ _____ <input type="checkbox"/> EACH CHILD Fixed amount of \$ _____	C <input type="checkbox"/> MEMBER Fixed amount of \$ _____ <input type="checkbox"/> SPOUSE Fixed amount of \$ _____ <input type="checkbox"/> EACH CHILD Fixed amount of \$ _____

E - DESIGNATION OF BENEFICIARY(IES)

Last name, first name	Date of birth if minor YY MM DD	Relationship	%	Please check (see on reverse)
				<input type="checkbox"/> Revocable <input type="checkbox"/> Irrevocable
				<input type="checkbox"/> Revocable <input type="checkbox"/> Irrevocable

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. 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 member

Signature of employer's
representative

Date

WHITE - Desjardins Financial Security Life Assurance Company

YELLOW - Employer

PINK - Member

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 the Company's various financial services (insurance, annuities, credit, etc.). 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, avenue des Commandeurs
Lévis (Québec) G6V 6R2

For residents of all Canadian provinces, excluding British Columbia:

DFS may send information on its insurance products for retirees to those whose names appear on its client list. 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.

For residents of British Columbia:

DFS cannot use or communicate information contained in your file for commercial purposes without first receiving your written consent.

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 he or she reaches the majority.