

MEMBER'S CHANGE REQUEST

™ Trademark owned by Desjardins Financial Security Life Assurance Company

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

Name of employer	Group number	Division number
Last name of member	First name	Certificate number

B - REQUEST FOR EXEMPTION

<p>EXEMPTION - If my plan allows, I waive coverage under this(these) benefit(s): <input type="checkbox"/> health insurance <input type="checkbox"/> dental care since I am already covered under my spouse's plan.</p> <p>Date of the event: YY MM DD</p>	<p>TERMINATION OF EXEMPTION - As I am no longer covered by my spouse's plan, I wish to be covered again under this(these) benefit(s): <input type="checkbox"/> health insurance <input type="checkbox"/> dental care</p> <p>Date of the event: YY MM DD</p> <p>Coverage requested: <input type="checkbox"/> individual <input type="checkbox"/> single-parent <input type="checkbox"/> couple <input type="checkbox"/> family</p>
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C - ADDITION OF ELIGIBLE DEPENDENT(S)

Event: <input type="checkbox"/> spouse's loss of employment <input type="checkbox"/> marriage <input type="checkbox"/> separation or divorce						Coverage requested: <input type="checkbox"/> family					
<input type="checkbox"/> start of common-law relationship <input type="checkbox"/> birth <input type="checkbox"/> other, specify:						<input type="checkbox"/> couple <input type="checkbox"/> single-parent					
Last name and first name	Sex M / F	Relationship with member (spouse, child)	Date of birth			Dependent's status S = age 21 to 25, full-time student X = Disabled	Covered under another plan		Date of the event		
			YY	MM	DD		Health Yes/No	Dental Yes/No	YY	MM	DD

D - COVERAGE CHANGE OR CANCELLATION – Please complete the OPTIONAL LIFE INSURANCE section if applicable

I no longer have eligible dependents, so I would like to change to individual coverage effective: YY MM DD

I no longer have an eligible spouse, so I would like to change to single-parent coverage effective: YY MM DD

I no longer want my plan to cover the following dependents:

Last name, first name:	YY	MM	DD
Last name, first name:			

OPTIONAL LIFE INSURANCE (if applicable) - It is important to check your coverage before making your selection:

I am **cancelling** the optional life insurance: for dependents (spouse and children) for my spouse for dependent children

I am **continuing** the optional life insurance: for dependents (spouse and children) for my spouse for dependent children

E - MATERNITY LEAVE TEMPORARY LAYOFF PARENTAL LEAVE UNPAID LEAVE

Please check the provisions provided under your plan

<p>I wish to: <input type="checkbox"/> keep the benefits provided by my group insurance plan.</p> <p><input type="checkbox"/> cancel all benefits under my group insurance plan excluding the one that includes prescription drug coverage (Québec only).</p> <p><input type="checkbox"/> cancel the disability income insurance under my group insurance plan.</p>	<p>Date of beginning of leave: YY MM DD</p> <p>Expected return to work date: YY MM DD</p>
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F - OPTIONAL BENEFITS – You must complete an insurability report. Please use form No. 20009A if you are choosing the Optional Life Insurance or the Accidental Death and Dismemberment Insurance. Use form No. 98140E if you are choosing Critical Illness benefit 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 and enter the total amount requested	<input type="checkbox"/> ACCIDENTAL DEATH AND DISMEMBERMENT Complete only one section: A, B or C and enter the total amount requested	<input type="checkbox"/> CRITICAL ILLNESS Complete only one section: A, B or C and enter the total amount requested									
<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:33%;"> A <input type="checkbox"/> MEMBER No. _____ times the annual salary </td> <td style="width:33%;"> B <input type="checkbox"/> MEMBER No. _____ \$ _____ segment <input type="checkbox"/> SPOUSE No. _____ \$ _____ segment </td> <td style="width:33%;"> C <input type="checkbox"/> MEMBER Fixed amount of \$ _____ <input type="checkbox"/> SEPOUSE Fixed amount of \$ _____ <input type="checkbox"/> EACH CHILD Fixed amount of \$ _____ </td> </tr> </table>	A <input type="checkbox"/> MEMBER No. _____ times the annual salary	B <input type="checkbox"/> MEMBER No. _____ \$ _____ segment <input type="checkbox"/> SPOUSE No. _____ \$ _____ segment	C <input type="checkbox"/> MEMBER Fixed amount of \$ _____ <input type="checkbox"/> SEPOUSE Fixed amount of \$ _____ <input type="checkbox"/> EACH CHILD Fixed amount of \$ _____	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:33%;"> A <input type="checkbox"/> MEMBER No. _____ times the annual salary </td> <td style="width:33%;"> B <input type="checkbox"/> MEMBER No. _____ \$ _____ segment <input type="checkbox"/> SPOUSE No. _____ \$ _____ segment </td> <td style="width:33%;"> C <input type="checkbox"/> MEMBER Fixed amount of \$ _____ <input type="checkbox"/> SEPOUSE Fixed amount of \$ _____ <input type="checkbox"/> EACH CHILD Fixed amount of \$ _____ </td> </tr> </table>	A <input type="checkbox"/> MEMBER No. _____ times the annual salary	B <input type="checkbox"/> MEMBER No. _____ \$ _____ segment <input type="checkbox"/> SPOUSE No. _____ \$ _____ segment	C <input type="checkbox"/> MEMBER Fixed amount of \$ _____ <input type="checkbox"/> SEPOUSE Fixed amount of \$ _____ <input type="checkbox"/> EACH CHILD Fixed amount of \$ _____	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:33%;"> A <input type="checkbox"/> MEMBER No. _____ times the annual salary </td> <td style="width:33%;"> B <input type="checkbox"/> MEMBER No. _____ \$ _____ segment <input type="checkbox"/> SPOUSE No. _____ \$ _____ segment </td> <td style="width:33%;"> C <input type="checkbox"/> MEMBER Fixed amount of \$ _____ <input type="checkbox"/> SEPOUSE Fixed amount of \$ _____ <input type="checkbox"/> EACH CHILD Fixed amount of \$ _____ </td> </tr> </table>	A <input type="checkbox"/> MEMBER No. _____ times the annual salary	B <input type="checkbox"/> MEMBER No. _____ \$ _____ segment <input type="checkbox"/> SPOUSE No. _____ \$ _____ segment	C <input type="checkbox"/> MEMBER Fixed amount of \$ _____ <input type="checkbox"/> SEPOUSE Fixed amount of \$ _____ <input type="checkbox"/> EACH CHILD Fixed amount of \$ _____
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CANCELLATION OF OPTIONAL BENEFIT(S) - I wish to cancel the following benefit(s):

Optional life insurance Accidental death and dismemberment Critical illness

Signature of member	Signature of employer's representative	Date
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