Desjardins Insurance
LIFE • HEALTH • RETIREMENT

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

GROUP INSURANCE - CONTRACT ADMINISTRATION

APPLICATION FOR ENROLMENT

A - IDENTIFICATION

Please print.

☐ **New application** ☐ **Reinstatement**

Name of policyholder	Group no.	Division no.	Certificate no.

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/week

Current position:

B - COVERAGE SELECTION AND EXEMPTION

☐ Individual	If your plan allows, would you like 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.
☐ Exemption from the health care benefit ☐ Exemption from the dental care benefit	If your plan allows, you can waive coverage for one or both of these benefits. However, 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, couple or single-parent coverage.
- If you have more than 4 dependent children, please use another form no. 9147A or complete form no. 00291E.

SPOUSE

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

☐ Married
☐ Common-law spouse - Start date of cohabitation: YYYY MM DD

- Was a child born of this union? ☐ 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: ☐ Same as spouse (above) ☐ No ☐ Other

☐ Child with functional impairment [2]
☐ Child aged 18 or older [3] and full-time student - please specify: Period: 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: ☐ Same as spouse (above) ☐ No ☐ Other

☐ Child with functional impairment [2]
☐ Child aged 18 or older [3] and full-time student - please specify: Period: 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: ☐ Same as spouse (above) ☐ No ☐ Other

☐ Child with functional impairment [2]
☐ Child aged 18 or older [3] and full-time student - please specify: Period: 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: ☐ Same as spouse (above) ☐ No ☐ Other

☐ Child with functional impairment [2]
☐ Child aged 18 or older [3] and full-time student - please specify: Period: From YYYY MM DD To YYYY MM DD

Name of educational institution :

- **Note 1 : Care included in Extended health care benefit.**
- **Note 2 : Please complete form no. 09296E and return it to the address shown on the form.**
- **Note 3 : Refer to your policy for eligible age.**

*** Desjardins Insurance refers to Desjardins Financial Security Life Assurance Company (DSF).**

PLEASE COMPLETE THE BACK OF THIS FORM.

Desjardins Insurance refers to Desjardins Financial Security Life Assurance Company.

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. A new request should be sent.

In the last 12 months, have you used any form of tobacco, including electronic cigarettes or other tobacco substitutes?

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

OPTIONAL LIFE

☐ Member: ______ No. of units $ ____________ **OR** $ ____________ (Fixed amount) **OR** ______ No. of times the annual salary

☐ Spouse: ______ No. of units $ ____________ **OR** $ ____________ (Fixed amount)

☐ Each child: ______ No. of units $ ____________ **OR** $ ____________ (Fixed amount)

OPTIONAL ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D)

☐ Member: ______ No. of units $ ____________ **OR** $ ____________ (Fixed amount) **OR** ______ No. of times the annual salary

☐ Spouse: ______ No. of units $ ____________ **OR** $ ____________ (Fixed amount)

☐ Each child: ______ No. of units $ ____________ **OR** $ ____________ (Fixed amount)

OPTIONAL CRITICAL ILLNESS

☐ Member: ______ No. of units $ ____________ **OR** $ ____________ (Fixed amount) **OR** ______ No. of times the annual salary

☐ Spouse: ______ No. of units $ ____________ **OR** $ ____________ (Fixed amount)

☐ Each child: ______ No. of units $ ____________ **OR** $ ____________ (Fixed amount)

E - DESIGNATION OF BENEFICIARY(IES)

Please read section H 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 - Does not apply in Québec. (Please read section I before completing this section.)

Last name and first name of trustee			Relationship
Address - 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 the information on this form 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 Insurance 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 Desjardins Insurance, its agents and service providers to collect, use and disclose information about me, my spouse or my dependents to any person or organization including the pharmacies, health care practitioners, institutions, investigative agencies or insurers for the purposes of underwriting, administration, optimal health management, auditing and paying claims. 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 Insurance and give a copy to the member.

G - PERSONAL INFORMATION MANAGEMENT

Desjardins Insurance handles the personal information it has on you in a confidential manner. Desjardins Insurance keeps this information on file so that you may benefit from group insurance services offered by the Company. This information is consulted solely by Desjardins Insurance employees who need to do so in the course of their work. Desjardins Insurance may compile anonymized personal information for statistical and informational purposes. Desjardins Insurance may also communicate with plan members to provide them with optimal health management. 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 Insurance, 200, rue des Commandeurs, Lévis, Québec, G6V 6R2. Desjardins Insurance 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 Desjardins Insurance.

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.

For all other provinces: Complete this section only if you have named a minor beneficiary.

For the province of Québec: The provisions of the Civil Code apply. DO NOT complete this section.

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