



Desjardins

Insurance

LIFE • HEALTH • RETIREMENT

GROUP INSURANCE - DISABILITY CLAIMS

**DIRECT DEPOSIT - ENROLMENT OR CHANGES
DISABILITY CLAIMS**

Last name and first name of the member		Certificate or identification no.
Address - No., street, apartment		Policy or group or contract no.
City		Telephone no.
Province	Postal code	() -

I hereby authorize Desjardins Financial Security Life Assurance Company, hereinafter Desjardins Insurance, to deposit my benefit payment through the DIRECT DEPOSIT system into account at the financial institution indicated below:

Name of financial institution: _____

Address: _____

Institution no.: _____ **Transit/Branch no.:** _____ **Account no.:** _____

Please include a specimen cheque marked "VOID".

Any credit entered in my account in accordance with this authorization will be identified with a DIRECT DEPOSIT transaction code and I acknowledge that the credit in question shall constitute an amount paid in accordance with this authorization.

This authorization will be effective on _____ . The authorization will terminate following a 10-day written notice by either Desjardins Insurance or me.

Signature of member _____ **Date** _____

**Please return to: Desjardins Insurance
PO Box 1203 STN A
Toronto ON M5W 1G6**

**or by fax: 416-926-0697
1-844-409-6571**