

**DESJARDINS FINANCIAL SECURITY
LIFE ASSURANCE COMPANY**

Desjardins Financial Security is a component of the Desjardins Group, the largest integrated cooperative financial group in Canada, with assets exceeding the \$133 billion mark.

Desjardins Financial Security offers a wide array of financial risk management solutions and services through a wide network of national distributors. Our product portfolio consists of life, health, investment and retirement products designed to meet the diverse financial needs of Canadians seeking financial protection.



IT'S ABOUT YOU!



Desjardins
Financial Security®



Desjardins
Financial Security®

Contract Number

APPLICATION

- NEW ISSUE
 CHANGES



PLAN TYPE - Please select one of the following OPTIONS (1, 2, 3 or 4)

- OPTION 1 OPTION 2 OPTION 3 OPTION 4
OPTIONAL BENEFITS Prescription Drugs Hospital Dental Care

PROPOSED INSURED

Name and Address of Insured

First Name	Middle Name	Last Name
No. and Street		
City	Province	Postal Code

Date of Birth Age Place of Birth

Day	Month	Year	<input type="text"/>	<input type="text"/>
-----	-------	------	----------------------	----------------------

If in Canada less than 2 years, attach copy of IMM5292 or permanent resident card

In Canada since:

Height - Specify "FT/CM" Weight - Specify "LB/KG"

<input type="text"/>	Current	Last Year
----------------------	---------	-----------

Reason for Weight Change

Sex Status Language Social Insurance No.

Male Smoker English

Female Non-Smoker French

Occupation Current Employer

Telephone Numbers

Business Tel. No. Residence Tel. No. Other - Specify

TYPE OF COVERAGE - Applicable to all Plan Types and Benefits

- Individual Family Couple Single Parent
FOR EXISTING SOLO PLAN, PLEASE USE APPLICATION FORM 01224E.

SPOUSAL INFORMATION

Name and Address of Insured

First Name	Middle Name	Last Name
No. and Street		
City	Province	Postal Code

Date of Birth Age Place of Birth

Day	Month	Year	<input type="text"/>	<input type="text"/>
-----	-------	------	----------------------	----------------------

If in Canada less than 2 years, attach copy of IMM5292 or permanent resident card

In Canada since:

Height - Specify "FT/CM" Weight - Specify "LB/KG"

<input type="text"/>	Current	Last Year
----------------------	---------	-----------

Reason for Weight Change

Sex Status Language Social Insurance No.

Male Smoker English

Female Non-Smoker French

Date of marriage or cohabitation DD MM YY

Occupation Current Employer

Telephone Numbers

Business Tel. No. Residence Tel. No. Other - Specify

POLICYOWNER INFORMATION - Representative to Complete Life Disclosure Form (if OPTION 3 or 4 is selected and if any existing life policy is being replaced)

Proposed Insured Employer Other - Specify Below

First and Last Name of Policyowner Address City Province Postal Code Telephone Number

CHILDREN / DEPENDENTS

Children	First and Last Name of Child or Dependent	Height	Weight	Sex	Date of Birth	Status
Child (1)		CM FT	KG LB	<input type="checkbox"/> M <input type="checkbox"/> F	Day Month Year	<input type="checkbox"/> Smoker <input type="checkbox"/> Non-Smoker
Child (2)		CM FT	KG LB	<input type="checkbox"/> M <input type="checkbox"/> F	Day Month Year	<input type="checkbox"/> Smoker <input type="checkbox"/> Non-Smoker
Child (3)		CM FT	KG LB	<input type="checkbox"/> M <input type="checkbox"/> F	Day Month Year	<input type="checkbox"/> Smoker <input type="checkbox"/> Non-Smoker

BENEFICIARY INFORMATION - Applicable to the Proposed Insured only

First and Last Name of Beneficiary	Sex	Relationship	Status
<input type="text"/>	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="text"/>	<input type="checkbox"/> Revocable <input type="checkbox"/> Irrevocable

Are all the proposed insureds covered by a provincial health insurance plan? Yes No If "No", specify name(s)

EVIDENCE OF INSURABILITY

	*PI - Proposed Insured, SP - Spouse, CD - Children or Dependent	*PI	*SP	*CD			
Have any of the proposed insureds:		YES	NO	YES	NO	YES	NO
1. had any company decline to issue or re-instate, rate, modify, postpone, rescind, or cancel any life, disability, health insurance or critical illness coverage on their life?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. within the last five (5) years, been disabled and/or unable to perform normal daily activities from any cause for at least 2 weeks, and/or applied for or received benefits for disability?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. within the last two (2) years, been diagnosed with or consulted a physician for any illness, disease, disorder or physical impairment?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. within the last two (2) years, been taking or advised to take prescription medication for 21 days or more?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. ever suffered from, had symptoms or complained about a health problem, for which they have not yet consulted a physician, and/or been advised to undergo tests or surgery that have not yet taken place?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Have any of the proposed insureds ever consulted a health care professional, received treatment, had surgery, been hospitalized or been tested for a problem associated with:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Abnormalities of the Immune System Including AIDS <input type="checkbox"/> Alcohol/Drug Abuse <input type="checkbox"/> Alzheimer's <input type="checkbox"/> Backaches <input type="checkbox"/> Blood Disorder <input type="checkbox"/> Blood Vessel <input type="checkbox"/> Breast <input type="checkbox"/> Cancer/Tumour <input type="checkbox"/> Other Condition/Physical Impairment/Disease/Disorder, Please Specify: <input type="text"/>	<input type="checkbox"/> Diabetes <input type="checkbox"/> Ears (Excluding Otitis) <input type="checkbox"/> Eyes (Excluding Myopia and Presbyopia) <input type="checkbox"/> Epilepsy/Seizure Disorder <input type="checkbox"/> Gastro-intestinal System <input type="checkbox"/> Heart <input type="checkbox"/> Hepatitis <input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> High Cholesterol <input type="checkbox"/> High Triglycerides <input type="checkbox"/> Kidney/Bladder <input type="checkbox"/> Liver <input type="checkbox"/> Mental Disorder <input type="checkbox"/> Motor Neuron Disorder <input type="checkbox"/> Musculoskeletal Disorder <input type="checkbox"/> Nervous System	<input type="checkbox"/> Neurological Disorder <input type="checkbox"/> Parkinson's <input type="checkbox"/> Prostate <input type="checkbox"/> Respiratory Disorder <input type="checkbox"/> Sexually Transmitted Diseases (STD) <input type="checkbox"/> Stroke				
7. Are any of the proposed insureds pregnant? If "Yes", please provide name and due date. <input type="text"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Other than cold or flu medication or birth control pills, are any of the proposed insureds using or been advised to use prescription medication for any chronic or recurring condition or disorder? Or is anyone expected to take prescription medication in the next three (3) months? If "Yes", please complete the table below:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

TM® Trademarks owned by Desjardins Financial Security

MEDICAL QUESTIONNAIRE - TOBACCO, ALCOHOL AND DRUGS, AVOCATION AND SPORTS, CRIMINAL AND DRIVING RECORD, FAMILY HISTORY

*PI	*SP	*CD
YES NO	YES NO	YES NO
9. <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
10. <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
11. <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
12. <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
13. <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>

9. Within the past twelve (12) months, have any of the proposed insureds used any substance or product containing nicotine in any form or marijuana?

10. Please indicate the consumption of tobacco, alcohol and drugs for each proposed insured:

Proposed Insureds	Tobacco or Substitutes			Alcohol			Narcotics or Drugs		
	Type	Amount	Frequency	Type	Amount	Frequency	Type	Amount	Frequency

11. Within the last two (2) years, have any of the proposed insureds engaged in flying as a pilot, student pilot or crew member, motorized vehicle racing, parachuting, hang-gliding, scuba diving or other hazardous activities; or does anyone intend to do so? If "Yes", complete appropriate questionnaire(s).

12. Within the last five (5) years, have any of the proposed insureds been found guilty of a criminal offense, including suspension of driver's license?

13. Do any of the proposed insureds have a family (father, mother, brother, sister) history of cancer, heart disease, stroke, high cholesterol, high blood pressure, diabetes, kidney disease, multiple sclerosis, Huntington's chorea, polycystic kidney disease, colon polyps, muscular dystrophy, motor neuron disorder, Parkinson's disease, Alzheimer's disease or any other hereditary condition?

If "Yes", please complete the table below. In the case of cancer, specify the type.

In addition to the above: if any of the proposed insureds are female, please indicate if the maternal grandmother and aunts have a history of breast cancer.

Family Member (e.g. father, etc.)	Illnesses/Medical Conditions If cancer, specify the type	Age		
		At Onset of Illness	if Alive	At Death

PLEASE PROVIDE DETAILS TO ANY "YES" RESPONSES FROM QUESTIONS 1 - 5 and QUESTIONS 6, 11 or 12

Question No.	Name(s) of Proposed Insured	Explanation Details - Illnesses-Surgery-Accidents-Consultations-Etc. Give duration hospitalized, dates, treatments and prescribed medications in your explanation. Use separate sheet if necessary.

DECLARATION AND AUTHORIZATION WITH RESPECT TO THE COLLECTION AND COMMUNICATION OF PERSONAL INFORMATION TO THIRD PARTIES

For the purpose of determining insurability, managing my file and processing claims, I hereby authorize any person, corporate body, public or parapublic organization holding personal information regarding myself and my health condition, medical history, or my eligibility for benefits, including any physician, dentist or other practitioner, hospital, medical or paramedical clinic, insurance or reinsurance company, the Medical Information Bureau, personal information agents, market intermediaries, any financial institution, the policyowner, my employer or ex-employer, WCB/WSIB, the Canada Pension Plan, the government plan requiring or providing automobile insurance benefits on a no-fault basis, the provincial health insurance plan to communicate the said information to Desjardins Financial Security Life Assurance Company (hereinafter referred to as Desjardins Financial Security) or its reinsurers upon request. I also authorize Desjardins Financial Security to communicate the said information to the said third parties as well as to its reinsurers. For the same purpose and for the collection of the same type of information, I also authorize Desjardins Financial Security or its reinsurers to request an investigative report regarding myself and to use any information contained in other files. This authorization applies also to the collection, use and communication of personal information regarding my minor children. Modifications or alterations to this authorization will have no impact on its content nor bind the insurer. In the event that this authorization is revoked, the insurance will automatically terminate. I hereby authorize Desjardins Financial Security to use or communicate my social insurance number for income tax and administrative purposes. A photocopy of this authorization is as valid as the original. I hereby certify that the answers given above are accurate, complete and true. I agree that they form an integral part of my insurance application. I hereby acknowledge that I have read the Personal Information Notice and Policy Information Management. **The insurance will become effective on the date that the evidence of insurability is approved by Desjardins Financial Security.** Any false declaration may result in the cancellation of the insurance.

Name and Address of Physician <input type="text"/>	Signature of Dependent Children aged 16 and over <input type="text"/>	Signature of Proposed Insured <input type="text"/>
Dated at - Place Day Month Year <input type="text"/>	Signature of Spouse <input type="text"/>	Signature of Policyowner <input type="text"/>
		Signature of Witness <input type="text"/>

NOTICE OF MODIFICATION - DESJARDINS FINANCIAL SECURITY USE ONLY

PRE-AUTHORIZED CHEQUE AUTHORIZATION

I authorize Desjardins Financial Security Life Assurance Company to draw and issue cheques in its favour for payment of premiums on my insurance policy. This authorization may be cancelled at any time upon written notice by either party to the other.

Name of Depositor(s)

Name and Address of Financial Institution

Account No.

Withdrawal Premium Due Date **or** Choose 1 - 28

Date

Signature of Depositor(s)

Please attach a specimen cheque marked "Void".

RECEIPT FOR AMOUNT PAID

Desjardins Financial Security Life Assurance Company acknowledges receipt of \$

Date

Signature of Representative Print Name of Representative

Field Office Code Name of Field Office Telephone Number

VERIFICATION INFORMATION

The undersigned representative verified the identification of the **Policyowner** by examining one of the following forms of identification.

Type of Document	Jurisdiction	Dated at	this	day of	year
	<input type="checkbox"/> Driver's License	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	<input type="checkbox"/> Birth Certificate	Document Number	Signature of Representative		
	<input type="checkbox"/> Passport	<input type="text"/>	X		
<input type="checkbox"/> Other - Please specify	<input type="text"/>	Print Name of Representative			<input type="text"/>

REPRESENTATIVE'S DECLARATION

I hereby certify that I have asked the individuals concerned all the questions on this application, and have entered their answers. I certify that, to the best of my knowledge, the answers are complete and true.

Representative's Name	Rep. Code	Field Office Name	Field Office Location	Field Office Code
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Telephone Number	Fax Number	Email Address	Other - Please Specify	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
Dated at - Place	Day	Month	Year	Signature of Representative
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	X

If another insurance application has been submitted or is currently being reviewed with this application, please provide the names and birth dates of the proposed insureds.

Name(s) of Proposed Insured(s)	Sex	Date of Birth		
		Day	Month	Year
	<input type="checkbox"/> M <input type="checkbox"/> F			
	<input type="checkbox"/> M <input type="checkbox"/> F			
	<input type="checkbox"/> M <input type="checkbox"/> F			
	<input type="checkbox"/> M <input type="checkbox"/> F			
	<input type="checkbox"/> M <input type="checkbox"/> F			

CONDITIONAL PREMIUM RECEIPT IN THE EVENT OF DEATH

Desjardins Financial Security Life Assurance Company acknowledges receipt of the amount of \$

from

Under this Conditional Premium Receipt, coverage providing for payment of a benefit on the death of the proposed insured(s) takes effect on the date the insurance application is signed, subject to the following terms and conditions.

1. **Initial Premium Payment:** On signing the application, the applicant must pay at least one (1) monthly premium or 1/20 of the premium for a single premium policy, depending on the policy applied for in this application; however, any payment exceeding one (1) monthly premium for coverage of \$500,000 is not required. The Company sets a \$500,000 limit on the Conditional Premium Receipt, which cannot be invalidated even if the initial premium paid is higher than the minimum required. If payment of the initial premium is not honoured, this receipt will be deemed to have never taken effect.
2. **Maximum Death Benefit:** The total death benefit available under all identical conditional premium receipts issued by the Company for the same person may not exceed \$500,000.
3. **Policy Internal Replacement:** If the insured dies before the new policy becomes effective, Desjardins Financial Security Life Assurance Company agrees to pay the beneficiary the higher of (a) the amount payable under the replaced policy or (b) the amount payable under the Conditional Premium Receipt.
4. **Exclusions:** No death benefit is paid under this receipt:
 - a) if the proposed insured is under thirty-one (31) days old or over age sixty-five (65) on the date the application is signed;
 - b) in the case of group insurance conversion;
 - c) if the proposed insured has ever submitted a life insurance application which was rejected or deferred by our Company or by another insurer;
 - d) if, on the date the Conditional Premium Receipt is signed, the proposed insured suffers from, or has suffered from, heart disease, a tumour, cancer, AIDS or tested positive for AIDS;
 - e) if the proposed insured commits suicide, whether sane or insane, the Company's liability is limited to the refund of the premium paid on signing the application;
 - f) in the case of additional benefits;
 - g) if this Conditional Premium Receipt has not been signed on the same date as the application form.
5. **Statements:** Any statements made by the policyowner or the proposed insureds in this application for the life insurance may be contested with respect to this Conditional Premium Receipt.
6. **Termination of Coverage under the Conditional Premium Receipt:** Coverage under this receipt terminates on the earliest of the following dates:
 - a) the effective date of the coverage applied for;
 - b) the 91st day following the date the application is signed;
 - c) the issue date of a policy that differs from the policy applied for, such policy being made as a counter-offer by the Company to the policyowner;
 - d) the date on which the Company sends the policyowner a letter of notification that coverage under the Conditional Premium Receipt has terminated or that this application for life insurance has been rejected.

No Company Representative is authorized to amend this Conditional Premium Receipt.

Having read this receipt, the policyowner acknowledges that he/she understands the terms and conditions stipulated herein and that the proposed insureds are not affected by any of the exclusions in section 4.

Dated at	this	day of	year

Signature of Representative

--

Signature of Policyowner(s) and/or Proposed Insured

--

Print Name of Representative

--

PERSONAL INFORMATION NOTICE

Any application for life insurance requires the collection of information that is as complete as possible. Such information is of a medical, personal or financial nature.

In order to achieve a more equitable underwriting of each applicant, the Company, like most insurance companies, deals with an organization called the Medical Information Bureau.

Any information regarding your insurability will be treated as confidential. However, the Company may forward a summary to the Medical Information Bureau, a non-profit organization made up of life insurance companies that provides an exchange of information on behalf of member companies.

If you apply for life or health insurance, or if you submit a claim to a member company, the Bureau will give that Company, upon request, the information it has on you.

If the Bureau receives a request from you, it will supply the information contained in your file. If you question the accuracy of information in the Bureau's file, you may ask them to rectify any possible error. The address of the Bureau is as follows: Medical Information Bureau, 330 University Ave., Suite 102, Toronto ON M5G 1R7 Canada. Telephone No. (416) 597-0590.

The Company may also communicate information in its possession to other life insurance companies to which you may have submitted a life or health insurance application or a claim.

POLICY 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, rue des Commandeurs, Lévis (Québec) G6V 6R2

DFS may send information on its promotions or offer new products to those whose names appear on its client list. DFS may also give its client list to another component of the Desjardins Group for the same purposes. 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.