

® Registered trademark owned by Desjardins Financial Security Life Assurance

Contract no.												
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**1: GENERAL INFORMATION - Please print**

A- Insured				B- Spouse - Complete only if coverage is requested for spouse			
Last name		First name		Last name		First name	
		Initials				Initials	
Sex <input type="checkbox"/> M <input type="checkbox"/> F	Social insurance number	Date of birth DD MM YY	<input type="checkbox"/> Smoker <input type="checkbox"/> Non-smoker	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Social insurance number	Date of birth DD MM YY	<input type="checkbox"/> Smoker <input type="checkbox"/> Non-smoker
Place of birth (province or country)		If in Canada less than 2 years, in Canada since DD MM YY		Place of birth (province or country)		If in Canada less than 2 years, in Canada since DD MM YY	
Address				Address			
Postal code				Telephone			
				Res. ( ) Bus. ( )			
Are you covered by: • Employment Insurance <input type="checkbox"/> Yes <input type="checkbox"/> No • a provincial health insurance plan <input type="checkbox"/> Yes <input type="checkbox"/> No • WCB/WSIB <input type="checkbox"/> Yes <input type="checkbox"/> No				Date of marriage or cohabitation DD MM YY		Occupation	
Please explain each "NO":				Are you covered under a provincial health insurance plan? <input type="checkbox"/> Yes <input type="checkbox"/> No - If not, please explain:			

**2: INSURED'S BENEFICIARIES**

First name	Last name	Relationship	Percentage	
				<input type="checkbox"/> revocable <input type="checkbox"/> irrevocable
				<input type="checkbox"/> revocable <input type="checkbox"/> irrevocable
				<input type="checkbox"/> revocable <input type="checkbox"/> irrevocable
				<input type="checkbox"/> revocable <input type="checkbox"/> irrevocable

**3: INSURANCE IN FORCE  none**

Company name	Contract number	Issue date	Amount of coverage	Life coverage to be replaced by this application	
				Yes*	No
INSURED		DD MM YY		<input type="checkbox"/>	<input type="checkbox"/>
INSURED		DD MM YY		<input type="checkbox"/>	<input type="checkbox"/>
SPOUSE		DD MM YY		<input type="checkbox"/>	<input type="checkbox"/>
SPOUSE		DD MM YY		<input type="checkbox"/>	<input type="checkbox"/>

\* Representative to complete the life insurance disclosure form.

**4: POLICYOWNER**

<input type="checkbox"/> Insured	<input type="checkbox"/> Employer
<input type="checkbox"/> Other - name and address	
Tel.: ( )	

**5: INSURED'S JOB CHARACTERISTICS  Salaried employee  Self-employed  Unemployed**

Occupation			Level of education		Field of study	
Number of months worked per year	Number of hours worked per week	Employed since DD MM YY	Gross annual income		Since what date? DD MM YY	

**Division of tasks**

Office work	%	Super-vision	%	Sales	%	Physical or manual labour	%	Driving a vehicle	%	Other, (specify) %	
Employer								Nature of business			
Address										Telephone ( )	
										Fax ( )	
										Postal code	

**IF SELF-EMPLOYED and applying for Disability Insurance:** Self-employed workers must provide proof of income, such as most recent income tax statement, pay stub or employment contract. If operations began less than one year ago, please enclose a copy of the statement of income.

<input type="checkbox"/> Sole proprietor	<input type="checkbox"/> Stock company	<input type="checkbox"/> Partnership	Interest %	Number of full-time employees	Incorporation date of company DD MM YY	Number of years as owner
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**6: SELECTION OF BENEFITS**

<p><b>Occupation category of insured:</b>  <input type="checkbox"/> 4A <input type="checkbox"/> 3A <input type="checkbox"/> 2A <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> IC <input type="checkbox"/> X</p> <p><b>LIFE INSURANCE - insured</b>                  Minimum: \$20,000                  Maximum: \$500,000 \$ <u>AMOUNT SELECTED</u> (Units of \$5,000)</p> <p><b>ACCIDENT INSURANCE - insured</b>                  Minimum: \$20,000                  Maximum: \$500,000 \$ <u>AMOUNT SELECTED</u> (Units of \$5,000)</p> <p><b>LIFE AND ACCIDENT INSURANCE - dependent children</b>                  1. <input type="checkbox"/> \$5,000    2. <input type="checkbox"/> \$10,000</p> <p><b>DISABILITY INSURANCE - only available to insured</b>                  This plan provides non-taxable disability insurance benefits.                  Minimum: \$400                  Maximum: \$6,000    1. \$ <u>SELECTED MONTHLY AMOUNT</u> (Units of \$100)</p> <p>ELIMINATION PERIOD:                  2. <input type="checkbox"/> 14 days    4. <input type="checkbox"/> 60 days                  3. <input type="checkbox"/> 30 days    5. <input type="checkbox"/> 120 days</p> <p>INDEXATION (CPI, max. 4%)                  6. <input type="checkbox"/> Yes</p> <p>DISABILITY BENEFIT PERIOD:                  a. <input type="checkbox"/> 5 years    b. <input type="checkbox"/> until age 65</p> <p>OWN OCCUPATION BENEFIT PERIOD:                  c. <input type="checkbox"/> 24 months (available for all categories)                  d. <input type="checkbox"/> 60 months (available for categories 3A and 4A)</p>	<p><b>Occupation category of spouse:</b>  <input type="checkbox"/> 4A <input type="checkbox"/> 3A <input type="checkbox"/> 2A <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> IC <input type="checkbox"/> X</p> <p><b>LIFE INSURANCE - spouse</b>                  Minimum: \$20,000                  Maximum: \$500,000 \$ <u>AMOUNT SELECTED</u> (Units of \$5,000)</p> <p><b>ACCIDENT INSURANCE - spouse</b>                  Minimum: \$20,000                  Maximum: \$500,000 \$ <u>AMOUNT SELECTED</u> (Units of \$5,000)</p> <p><b>EXTENDED HEALTH CARE INSURANCE (includes travel insurance)</b>                  Offered only if all insureds are covered by the provincial health insurance plan                  COVERAGE SELECTED: <input type="checkbox"/> Individual <input type="checkbox"/> Family <input type="checkbox"/> Single-parent <input type="checkbox"/> Couple  <input type="checkbox"/> OPTION A    <input type="checkbox"/> OPTION B    <input type="checkbox"/> OPTION C                  Drug Card Plan    Standard Plan    Basic Plan</p> <p><b>DENTAL CARE INSURANCE -</b> 1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No                  Only offered if the EXTENDED HEALTH CARE coverage is selected and approved</p> <p><b>BUSINESS EXPENSE INSURANCE</b>                  Minimum: \$500                  Maximum: \$5,000    1. \$ <u>SELECTED MONTHLY AMOUNT</u> (Units of \$100)                  ELIMINATION PERIOD: 2. <input type="checkbox"/> 30 days    3. <input type="checkbox"/> 120 days                  DISABILITY BENEFIT PERIOD: 24 months</p>
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**7: COMPANY BUSINESS EXPENSES - Complete only if applying for Business Expense Insurance**

Number of partners (including the insured)	Do you share any business expenses? <input type="checkbox"/> Yes <input type="checkbox"/> No	If so, what is your share of the incurred expenses? %
<b>MONTHLY EXPENSES</b>		
Rent, electricity, telephone and other public services	+ _____	Depreciation of equipment and premises belonging to the insured
Personnel salaries and benefits	+ _____	Postage and office supplies
Janitorial services	+ _____	Property taxes for the place of business
Professional services of an outside accountant	+ _____	Loan interest payment
Leasing and amortization of equipment, including automobile	+ _____	Professional liability insurance
Professional dues	+ _____	Amortization or periodic repayments of capital, including mortgages
Business taxes and licences	+ _____	
Must attach a copy of the financial statements for the last full year of operation. If operations began less than one year ago, please enclose a copy of the statement of income.		<b>TOTAL</b> _____

**8: INSURABILITY REPORT**

	FIRST NAME	LAST NAME	SEX	DATE OF BIRTH	HEIGHT	WEIGHT	WEIGHT 1 YEAR AGO	REASON FOR CHANGE IN WEIGHT (IF APPLICABLE)
INSURED				DD MM YY				
SPOUSE				DD MM YY				
CHILDREN				DD MM YY				
				DD MM YY				
				DD MM YY				
				DD MM YY				

<p style="text-align: center;"><b>INSURED</b></p> <p>Have you used tobacco in any form over the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No                  Please answer for all three (3) substances</p> <p>What is your weekly consumption of:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%;"></td> <td style="width:33%;">tobacco</td> <td style="width:33%;">alcoholic beverages</td> <td style="width:33%;">narcotics or drugs</td> </tr> </table> <p style="text-align: center;"><b>FAMILY HISTORY</b></p> <table style="width:100%; border: none;"> <tr> <td style="width:10%;"></td> <td style="width:10%;">Age if living</td> <td style="width:10%;">Age at death</td> <td style="width:80%;">STATE OF HEALTH OR CAUSE OF DEATH</td> </tr> <tr> <td>Father</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Mother</td> <td></td> <td></td> <td></td> </tr> <tr> <td>No. of brothers</td> <td><input type="text"/></td> <td></td> <td></td> </tr> <tr> <td>No. of sisters</td> <td><input type="text"/></td> <td></td> <td></td> </tr> </table>		tobacco	alcoholic beverages	narcotics or drugs		Age if living	Age at death	STATE OF HEALTH OR CAUSE OF DEATH	Father				Mother				No. of brothers	<input type="text"/>			No. of sisters	<input type="text"/>			<p style="text-align: center;"><b>SPOUSE</b></p> <p>Have you used tobacco in any form over the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No                  Please answer for all three (3) substances</p> <p>What is your weekly consumption of:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%;"></td> <td style="width:33%;">tobacco</td> <td style="width:33%;">alcoholic beverages</td> <td style="width:33%;">narcotics or drugs</td> </tr> </table> <p style="text-align: center;"><b>FAMILY HISTORY</b></p> <table style="width:100%; border: none;"> <tr> <td style="width:10%;"></td> <td style="width:10%;">Age if living</td> <td style="width:10%;">Age at death</td> <td style="width:80%;">STATE OF HEALTH OR CAUSE OF DEATH</td> </tr> <tr> <td>Father</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Mother</td> <td></td> <td></td> <td></td> </tr> <tr> <td>No. of brothers</td> <td><input type="text"/></td> <td></td> <td></td> </tr> <tr> <td>No. of sisters</td> <td><input type="text"/></td> <td></td> <td></td> </tr> </table>		tobacco	alcoholic beverages	narcotics or drugs		Age if living	Age at death	STATE OF HEALTH OR CAUSE OF DEATH	Father				Mother				No. of brothers	<input type="text"/>			No. of sisters	<input type="text"/>		
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**MEDICATIONS - List any medications the insured, spouse or any dependent children are currently using or expect to be using in the next 3 months**

NAME OF THE INSURED	NAME OF THE DRUG/MEDICATION/SERUM	MONTHLY COST	LENGTH OF TIME ON THIS PRESCRIPTION



### 11: 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 application for insurance. I hereby acknowledge that I have read the notice regarding the establishment of a personal information file, as well as the notice regarding the Medical Information Bureau and that I have received a copy thereof. **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.

This sale involves the designated representative/firm and Desjardins Financial Security. The designated representative/firm is independent and deals with different insurance companies, including Desjardins Financial Security. In return of this sale, it is possible that the designated representative/firm receives commissions as compensation plus a bonus or other incentives as additional compensation. This sale does not commit the designated representative/firm from selling any other product or service from Desjardins Financial Security.

Name and address  
of physician

Signature of insured

Signature of spouse

Signature of witness

Date

Signature of dependent children aged 16 and over to be insured

### 12: POLICYOWNER'S DECLARATION

I declare that the information contained in this application is complete and true, and agree that it is an integral part of the application for insurance. The insurance will become effective on the date the evidence of insurability is approved by Desjardins Financial Security Life Assurance Company, or on a later date as requested by the policyowner if this date is approved by the insurer.

Signature of policyowner  
if different from insured:

Date

### 13: 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

Representative Name	Code	Commission sharing	E-mail Address	Field Office Name	Code
		%			
		%			

Telephone No. of representative: Bus.: ( ) \_\_\_\_\_ Cell.: ( ) \_\_\_\_\_

Signature of representative(s) \_\_\_\_\_ Date \_\_\_\_\_

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

Name \_\_\_\_\_ Date of birth \_\_\_\_\_

### NOTICE OF MODIFICATION - DESJARDINS FINANCIAL SECURITY USE ONLY



### NOTICE REGARDING 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, rue des Commandeurs, Lévis (Québec) G6V 6R2

#### For residents of all Canadian provinces, excluding British Columbia:

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 clients 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.

#### For residents of British Columbia:

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

### NOTICE REGARDING THE MEDICAL INFORMATION BUREAU

The information regarding your insurability is treated confidentially. However, Desjardins Financial Security or its reinsurers may provide a summary of this information to the Medical Information Bureau, a non-profit organization created by life insurance companies for the exchange of information between member companies. If you enrol in life or health insurance with a company that is a member of the Bureau, or if you file a claim for benefits or indemnities, upon request the Bureau will provide the company with the information it holds regarding you.

Upon receipt of a request from you, the Bureau will disclose the information contained in your file. If you question the accuracy of the Bureau's information, you may ask that the information be rectified by writing to the Medical Information Bureau at 330 University Avenue, Toronto, Ontario M5G 1R7. The telephone number is: 416-597-0590.

### NOTICE REGARDING THE EFFECTIVE DATE OF THE POLICY

Please be advised that the insurance will become effective on the date that the evidence of insurability is approved by Desjardins Financial Security.