



E - INSURABILITY - SECTION 1

TO QUALIFY, YOU MUST ANSWER "NO" TO QUESTIONS 1 TO 5. If you do qualify, please complete Section "2".

First name	Last name at birth	Date of birth		
		YYYY	MM	DD
Total individual life insurance, critical illness (CI), long term care (LTC) and accidental death or dismemberment (ADD) insurance in force:		LTC \$	Life \$	
		ADD \$	CI \$	
Height		ft	in or	cm
Weight			lb or	kg
Cause of any weight change of 4.5 kg (10 lbs) or more in the last year.				
1- Do you currently need or use the assistance or supervision of another person in performing any of the following activities (circle all that apply): bathing; dressing; moving in/out of a bed or chair; toileting; bowel/bladder control; eating; taking your medications; walking inside; walking outside?		Yes	No	
		<input type="checkbox"/>	<input type="checkbox"/>	
2- Do you currently need or use the assistance or supervision of another person in performing any of the following activities for a physical or psychological reason (circle all that apply): using the telephone; managing finances; doing housework; doing laundry; transportation; shopping; meal preparation?		<input type="checkbox"/>	<input type="checkbox"/>	
3- Do you currently use any of the following: a walker; wheelchair; oxygen; hospital bed; dialysis; respirator; quad cane (4-pronged cane); motorized cart?		<input type="checkbox"/>	<input type="checkbox"/>	
4- Do you have diabetes AND have you ever had any of the following conditions: circulatory disease (other than well controlled hypertension); skin or leg ulcers; stroke/TIA or mini-stroke; neuropathy; kidney failure; retinopathy?		<input type="checkbox"/>	<input type="checkbox"/>	
5- Have you had, do you currently have, or have you ever been diagnosed or treated for any of the following medical conditions?		<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Acquired Immune Deficiency Syndrome (AIDS), HIV Positive or AIDS Related Complex (ARC) <input type="checkbox"/> Alzheimer's Disease <input type="checkbox"/> Amyotrophic Lateral Sclerosis (ALS or Lou Gehrig's Disease) <input type="checkbox"/> Liver Cirrhosis <input type="checkbox"/> Memory Loss, Senility, Dementia or Organic Brain Syndrome <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Cancer of two or more sites (excluding skin) or Metastatic Cancer (Cancer that has spread from the cancer original organ) <input type="checkbox"/> Muscular Dystrophy <input type="checkbox"/> More than one mini-stroke (TIA), Stroke or Cerebrovascular Accident (CVA) <input type="checkbox"/> Parkinson's Disease <input type="checkbox"/> Neurogenic Bladder <input type="checkbox"/> Kidney Failure <input type="checkbox"/> Amputation due to disease <input type="checkbox"/> Huntington's Disease <input type="checkbox"/> Paraplegia <input type="checkbox"/> Quadriplegia				

E - INSURABILITY - SECTION 2

If the answer is "YES" to any of the following questions, please provide relevant details in the "Explanation" area, page 4.

Within the past five (5) years, have you received advice or medical treatment, consulted with a health care professional, taken any medications, been medically diagnosed, been confined to a hospital, nursing care facility or any other institution for any of the following conditions:	Yes	No
6- Heart attack, high blood pressure, congestive heart failure (CHF), heart surgery, angioplasty, stroke, transient ischemic attack (TIA), mini-stroke, chest pain, irregular heart beat or other heart condition?	<input type="checkbox"/>	<input type="checkbox"/>
7- Cancer, tumor, Hodgkin's disease, lymphoma, other malignancy or growth, anemia or other blood disorder?	<input type="checkbox"/>	<input type="checkbox"/>
8- Diabetes: either insulin-dependent or non-insulin dependent, diseases of the pancreas or liver, hepatitis?	<input type="checkbox"/>	<input type="checkbox"/>
9- Brain disorder, mental, emotional or nervous disorder, depression, confusion, anxiety, alcoholism, drug addiction, fainting spells, black outs, epilepsy, seizures, convulsions, or other neurological disorder?	<input type="checkbox"/>	<input type="checkbox"/>
10- Emphysema, asthma, COPD (chronic obstructive pulmonary disease), shortness of breath, other lung problems or breathing conditions?	<input type="checkbox"/>	<input type="checkbox"/>
11- Osteoarthritis, rheumatoid arthritis, osteoporosis, pain in the muscles or joints, disorders of the bones, joints or spine, fracture, hip, knee or other joint replacement, amputation, or any conditions causing crippling, limited motion or requiring adaptive devices?	<input type="checkbox"/>	<input type="checkbox"/>
12- Paralysis, numbness, visual disturbances, balance problems, falls, tremors, skin ulcers?	<input type="checkbox"/>	<input type="checkbox"/>
13- Has any future surgery, diagnostic tests, or medical treatment been planned, discussed or recommended?	<input type="checkbox"/>	<input type="checkbox"/>
14- Have you received home care, adult day care, confinement to a nursing home, home for the aged, or other institution, or recommendation that you receive any such care?	<input type="checkbox"/>	<input type="checkbox"/>
15- Have you consulted with or been treated by a health professional for any reason not previously stated (excluding podiatrists, chiropractors, dentists, and routine eye exams)?	<input type="checkbox"/>	<input type="checkbox"/>
16- Are you currently suffering from a disability, receiving disability or worker's compensation benefits?	<input type="checkbox"/>	<input type="checkbox"/>

F - STATEMENTS AND AUTHORIZATIONS

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The Policyowner and the Proposed Insured declare that all answers provided in this application, or in any other questionnaire or form relating to it, are true and complete to the best of their knowledge. The same applies to answers provided during interviews, over the telephone or otherwise, to questions concerning insurability. They understand that Desjardins Financial Security Life Assurance Company will issue the policy or policies based on these answers and statements.

The Policyowner and the Proposed Insured acknowledge that:

- Any misrepresentation, including the misrepresentation of smoking habits, may void the policy;
- They have read the Notice regarding MIB (page 7) / Personal Information Management (page 8), and have received a copy of these notices.

Each Proposed Insured agrees to have insurance issued on them.

Each Policyowner and Proposed Insured have read this section before signing it.

The Policyowner acknowledges that:

- He was given an accurate description of the chosen protections;
- The exclusions applicable to the protections were clearly explained;
- That the Representative has disclosed in writing the names of all life and health insurance companies on whose behalf he sells products that he receives commissions for the sale of their life and health insurance products and that he may qualify for additional compensation, such as bonuses and non-monetary benefits, like travel incentives.

POLICYOWNER 1 IDENTIFICATION		POLICYOWNER 2 IDENTIFICATION	
<input type="checkbox"/> Driver's licence	<input type="checkbox"/> Citizenship card	<input type="checkbox"/> Driver's licence	<input type="checkbox"/> Citizenship card
<input type="checkbox"/> Birth certificate	<input type="checkbox"/> Health insurance card*	<input type="checkbox"/> Birth certificate	<input type="checkbox"/> Health insurance card*
<input type="checkbox"/> Passport		<input type="checkbox"/> Passport	

* Not permitted in Manitoba, Ontario and Prince Edward Island.

Number of the document used for identification: _____

Place issued: _____

Expiry date (YYYY/MM/DD): _____

X _____
Signature of Policyowner 1

Number of the document used for identification: _____

Place issued: _____

Expiry date (YYYY/MM/DD): _____

X _____
Signature of Policyowner 2

X _____
Signature of Proposed Insured

Name (block letters) of Representative

() _____
Telephone Number of Representative

Name (block letters) of Training Supervisor

X _____
Signature of Representative, Check if Trainee

X _____
Signature of Training Supervisor

Signed at _____, this _____ day of _____ 20__ YY

NOTICE OF MODIFICATION (Head Office use only)

Please sign the Authorization to collect and communicate personal information sections on page 7

Account holder name and account number

Last and first name(s) of Account Holder(s)		Telephone number
Address (Street, City, Province)		Postal code
Name and address of financial institution	Transit number	Account number

Authorization of withdrawal

I authorize Desjardins Financial Security Life Assurance Company (hereinafter "DFS") and the financial institution where I have my account or any other financial institution I may appoint, to debit the following amount(s) according to my instructions, at the frequency indicated:

Monthly Semi-Annual Annual

Draw day (select between 1st and 28th): _____

Contract number(s)	Amount to be withdrawn
	Total

Special Instructions

Type of PAD Agreement: Personal/individual Business

Waiver
I agree to waive any written notice before the first debit is made or when any change is made to the above debit.

Change or cancellation
I will advise DFS of any changes to this Agreement at least 10 business days prior to the next withdrawal.

I can cancel this Agreement at any time by sending a notice to DFS at least 10 business days prior to the next withdrawal.

I may obtain a sample cancellation form or more information on my right to cancel a PAD agreement by consulting my financial institution or by visiting www.cdnpay.ca.

The cancellation of this Agreement does not terminate the Policyowner's obligations towards his contract(s).

DFS can cancel the PAD agreement by sending a 30-day notice to the Policyowner. The agreement can also be cancelled if the financial institution refuses the pre-authorized debits for any reason.

Authorization to collect and communicate personal information
I consent to the disclosure of the personal information in this Agreement to DFS's financial institution and to the holder of the contract(s) paid through this Agreement.

Signature(s)
I guarantee that all persons whose signatures are required for this account have signed this agreement.

Reimbursement

I have certain rights of recourse if a PAD does not comply with the terms of this Agreement. For example, I have the right to receive reimbursement for any PAD that is not authorized or that is not compatible with the terms of this PAD Agreement. For more information on my rights of recourse, I may consult with my financial institution or visit www.cdnpay.ca.

Signature of account holder(s)

_____	_____
Signature of account holder	Date
_____	_____
Signature of the second account holder (Only if two signatures are required)	Date

IMPORTANT: Attach a personal cheque marked "VOID" to avoid errors in transcription.

AUTHORIZATION TO COLLECT AND COMMUNICATE PERSONAL INFORMATION

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For the sole purpose of determining my insurability, managing my file and processing claims, I hereby authorize Desjardins Financial Security Life Assurance Company:

- To collect from any individual, legal entity, public or parapublic organization, the personal information they have regarding me that is needed to process my file. Without drawing up an exhaustive list, the information may be collected from any health care professional or establishment, insurance companies, reinsurance companies, personal information brokers or investigation firms, the Policyowner, and my employer or ex-employers.

- To disclose to those individuals or organizations only the personal information it has regarding me that is necessary for the purpose of managing my file.
- To request, if applicable, an investigation report on me and to use the personal information contained in other files that are now closed.

A photocopy of this authorization is as valid as the original.

The Policyowner and Proposed Insured have read this authorization before signing it.

I authorize Desjardins Financial Security Life Assurance Company to use my social insurance number for administrative purposes.

Yes

No

Signature of Policyowner

Signature of Proposed Insured

Signature of Policyowner (if applicable)

Date

AUTHORIZATION TO COLLECT AND COMMUNICATE PERSONAL INFORMATION

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For the sole purpose of determining my insurability, managing my file and processing claims, I hereby authorize Desjardins Financial Security Life Assurance Company:

- To collect from any individual, legal entity, public or parapublic organization, the personal information they have regarding me that is needed to process my file. Without drawing up an exhaustive list, the information may be collected from any health care professional or establishment, insurance companies, reinsurance companies, personal information brokers or investigation firms, the Policyowner, and my employer or ex-employers.

- To disclose to those individuals or organizations only the personal information it has regarding me that is necessary for the purpose of managing my file.
- To request, if applicable, an investigation report on me and to use the personal information contained in other files that are now closed.

A photocopy of this authorization is as valid as the original.

The Policyowner and Proposed Insured have read this authorization before signing it.

I authorize Desjardins Financial Security Life Assurance Company to use my social insurance number for administrative purposes.

Yes

No

Signature of Policyowner

Signature of Proposed Insured

Signature of Policyowner (if applicable)

Date

NOTICE REGARDING MIB - GIVE TO POLICYOWNER

Information regarding your insurability will be treated as confidential. Desjardins Financial Security Life Assurance Company or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a non-profit membership organization of insurance companies, which operates an information exchange on behalf of its member. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 416-597-0590. If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth on its website at www.mib.com. The address of MIB's information office is 330 University Avenue Suite 501, Toronto, Ontario M5G 1R7.

Desjardins Financial Security Life Assurance Company, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.



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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.