Desjardins Financial Security®

95 St. Clair Avenue West, Toronto ON M4V 1N7

Application No. 000000

Application for Change, Reinstatement or Conversion

CHECK APPROPRIATE BOX

- ☐ Total conversion (entire policy) * (Complete Sections A and B)
- ☐ Partial conversion * (Complete Sections A and B)
  - ☐ Balance of Term Coverage, if any, to:
    - ☐ Continue unchanged with provisions appropriate to the reduced amount
    - ☐ Continue as a rider on the New Policy (Applicable to conversion of term policies only)
    - ☐ Discontinue coverage
- ☐ Option being exercised * (Complete Sections A and B)
  - (1) ☐ Periodic Purchase Option – Exercised because { ☐ Age ______ ☐ Married on ______ ☐ Child born on ______
    (For periodic Purchase Option – If not already provided, evidence of age must be submitted to the Company.)
  - (2) ☐ Family/Children Protection Benefit (Complete Sections A and B)

COMPLETE SECTIONS INDICATED

- ☐ Change coverage A, B, C, D
- ☐ Add coverage A, B, C, D
- ☐ Extra premium revision A, B, C
- ☐ Change smoker to non-smoker A, B, C
- ☐ Regular to preferred rate A, B, C
- ☐ Reduced paid-up A, B
- ☐ Reinstatement A, B, C, D

**** If amount applied for is greater than amount to be converted or additional benefits are being added, normal underwriting evidence is required. Please complete Section C.***

SECTION A - LIFE INSURED(S) AND POLICYOWNER(S)

Policy Number	☐ LIFE INSURED 1 ONLY ☐ LIFE INSURED 1 AND POLICYOWNER	☐ LIFE INSURED 2 ONLY ☐ LIFE INSURED 2 AND POLICYOWNER ☐ POLICYOWNER ONLY
First Name	☐ Mr ☐ Miss ☐ Mrs ☐ Ms ☐ ______	☐ Mr ☐ Miss ☐ Mrs ☐ Ms ☐ ______
Last Name		
Date of Birth	D M Y	D M Y
Social Insurance Number		
Residential Address		
	Postal Code	Postal Code
Telephone No.	(Res.) (Bus.)	(Res.) (Bus.)
Occupation and Annual Income	$	$
Employer (Name and City)		

SECTION B - DESCRIPTION OF REQUEST BY INSURED

Life Insured	Status		Amount of insurance		Plan	
			From	To	From	To
Life Insured 1	☐ Preferred	☐ Regular				
Description of request						

Life Insured	Status		Amount of insurance		Plan	
			From	To	From	To
Life Insured 2	☐ Preferred	☐ Regular				
Description of request						

New annual premium	Mode of payment
$	☐ Annual ☐ Semi-Annual ☐ PAC Monthly Please complete a PAC Authorization Form if monthly premiums are required.

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SECTION B - SPECIAL INSTRUCTIONS

Provide all details relevant to the request for change, reinstatement or conversion **(including any new beneficiary designations)**

SECTION C - EVIDENCE OF INSURABILITY

	Life Insured 1	Life Insured 2
1a) Total individual life insurance inforce	Life $	Life $
	ADD $	ADD $
	CI $	CI $
1b) Purpose of insurance	☐ Personal ☐ Business	☐ Personal ☐ Business

2a) Name, address and telephone no. of personal physician.

2b) Date and reason for last visit.

For each "yes" answer to the following questions, provide relevant details in the space provided under the question.	Life Insured 1 Yes	Life Insured 1 No	Life Insured 2 Yes	Life Insured 2 No
3) Is one of the Life Insureds completing this application for the purpose of replacing life coverage issued by our Company or another company? **If "yes", complete a life insurance disclosure form.** The cancellation of policy no.(s): ______ is conditional on the approval of this new application. **Cancellation form required.**	☐	☐	☐	☐
4) Has one of the Life Insureds submitted an application for life, disability or critical illness coverage with other companies? **If "yes", indicate the name of all the insurance companies concerned and the amount(s) applied for. Please indicate if this individual will be purchasing all of the coverages if approved.**	☐	☐	☐	☐

Life Insured	Name of Companies	Total Amounts Applied For	Total Amounts Purchased if Approved
Life Insured 1			
Life Insured 2			

	Life Insured 1 Yes	Life Insured 1 No	Life Insured 2 Yes	Life Insured 2 No
5) Has one of the Life Insureds applied for or received benefits for disability? **If "yes", indicate the name of the insurance company, date of onset, cause and period of disability.**	☐	☐	☐	☐

Life Insured	Name of Companies	Date of Onset of Disability	Cause of Disability	Period of Disability
Life Insured 1				
Life Insured 2				

	Life Insured 1 Yes	Life Insured 1 No	Life Insured 2 Yes	Life Insured 2 No
6) Has one of the Life Insureds ever submitted an application for life, disability or critical illness coverage or for reinstatement which was declined, postponed or approved subject to a restriction or extra premium? **If "yes", indicate the Company, the date and the reason for the refusal, the restriction or the extra premium.**	☐	☐	☐	☐
7) Have you, at this time, any sickness or injury which interferes with your ability to perform your regular occupation?	☐	☐	☐	☐

Application No. 000000

IF A PARAMEDICAL (FORM # 153691A) OR MEDICAL EXAMINATION IS REQUIRED, DO NOT COMPLETE QUESTIONS 8-20

8)						
LIFE INSURED 1	**Height** ft or cm	**Weight**	*Current* kg or lbs	*Last Year* kg or lbs	*Reason for change*	
LIFE INSURED 2	**Height** ft or cm	**Weight**	*Current* kg or lbs	*Last Year* kg or lbs	*Reason for change*	

For each "yes" answer to the following questions, provide relevant details in the space provided under the question.

Question	Life Insured 1 Yes	Life Insured 1 No	Life Insured 2 Yes	Life Insured 2 No
9a)	☐	☐	☐	☐
9b)	☐	☐	☐	☐
9c)	☐	☐	☐	☐
10)	☐	☐	☐	☐
11a)	☐	☐	☐	☐
11b)	☐	☐	☐	☐
12)	☐	☐	☐	☐
13)	☐	☐	☐	☐
14)	☐	☐	☐	☐

9a) Within the past twelve (12) months, has one of the Life Insureds smoked cigarettes, cigarillos, a pipe or used marijuana or any other form of tobacco, or tobacco substitute such as gum or nicotine patches? **If "yes", indicate the daily consumption and the type.**

Life Insured	Daily Consumption/Use	Type
Life Insured 1		
Life Insured 2		

9b) Is one of the Life Insureds a former smoker? **If "yes", indicate the date of cessation and daily consumption.**

Life Insured	Cessation Date	Daily Consumption/Use
Life Insured 1		
Life Insured 2		

9c) Are you an occasional cigar user? If yes, how many would you smoke per month: **Insured 1** ________ **Insured 2** ________

10) **Family History:**
Does one of the Life 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, 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, for critical illness coverage: If the Life Insured is female, please indicate if the maternal grandmother and aunts have a history of breast cancer.

Member of Family	Disease(s) (If cancer: type)	Age at Onset of Disease	Age if Alive	Age at Death

11a) Has one of the Life Insureds consumed, or do they currently consume alcoholic beverages? **If "yes", indicate the weekly consumption currently and over the past three (3) years if different.**

	Weekly Consumption	
Life Insured	**Currently**	**Consumption of Last Three (3) Years**
Life Insured 1		
Life Insured 2		

11b) Has one of the Life Insureds ever received or been advised to receive treatment for alcohol consumption, or are they members of a support group such as Alcoholics Anonymous, or been advised to reduce their consumption of alcohol? **If "yes", complete the Alcohol Consumption Questionnaire.**

12) Within the past five (5) years, has one of the Life Insureds been found guilty of a criminal offense, including driving with an alcohol blood level above the legal limit resulting in the loss of their driver's license? **If "yes", indicate date(s) the license was lost and the type of offense.**

Life Insured	Month/Year/Type	Month/Year/Type	Month/Year/Type
Life Insured 1			
Life Insured 2			

13) Within the past five (5) years, has one of the Life Insureds had a driving licence suspended, revoked, or been convicted of three or more moving violations? **If "yes", indicate the date of each infraction (if the exact date is unknown, indicate the year the infraction was committed).**

Life Insured	Month/Year/Type	Month/Year/Type	Month/Year/Type
Life Insured 1			
Life Insured 2			

14) Has one of the Life Insureds ever travelled outside Canada, or do they plan to do so within the next two (2) years for a reason other than a vacation? **If "yes", please complete the table below.**

Place	Departure Date	Length of Time	Purpose of Trip
	D M Y		
	D M Y		

Application No. 000000

For each "yes" answer to the following questions, please provide details in the "Explanation" section. If necessary, use an additional sheet, which must be signed, dated and identified by the application number. **If applying for the Children's Protection, please answer questions 6 and 17 for the children in the "Life Insured 2 and/or Children" column.**	Life Insured 1		Life Insured 2 and/or Children	
	Yes	No	Yes	No
15) Has one of the Life Insureds used drugs or narcotics without a medical prescription in the past or are they currently doing so? **If "yes", complete the Drug Usage Questionnaire.**	☐	☐	☐	☐
16) Within the past two (2) years, has one of the Life Insureds participated in activities such as flying, any hazardous sports or pastimes, such as skin or scuba diving, parachute jumping, mountain climbing, or powered vehicle racing (incl. motor boats) or plans to participate in such activities? **If "yes", complete the appropriate questionnaire(s).**	☐	☐	☐	☐
17) Has one of the Life Insureds ever consulted a health care professional, received treatment, had surgery or tests for a problem associated with:	☐	☐	☐	☐

☐ Heart	☐ Nervous system	☐ Liver	☐ Blood disorder
☐ Lung	☐ Mental disorder	☐ Breast	☐ Neurological disorders
☐ Diabetes	☐ Kidney/Bladder	☐ Cancer/Tumour	☐ Drug addiction
☐ Epilepsy/Seizure Disorder	☐ Alcoholism	☐ Bronchi	☐ Backaches
☐ Gastro-intestinal system	☐ High Blood Pressure	☐ High Cholesterol	☐ High Triglycerides
☐ Ears (excluding Otitis)	☐ Stroke	☐ Hypercholesterolemia	☐ Blood Vessel
☐ Abnormalities of the immune system including AIDS	☐ Parkinson's	☐ Eyes (excluding myopia and presbyopia)	☐ Hepatitis
	☐ Alzheimer's		☐ Prostate
	☐ Motor Neuron Disorder	☐ Sexually Transmitted Diseases (STD)	☐ Muscles
☐ Muscular Dystrophy	☐ Musculoskeletal Disorders		☐ Electrocardiogram

Question	Life Insured 1 Yes	Life Insured 1 No	Life Insured 2 and/or Children Yes	Life Insured 2 and/or Children No
18) Other than the above, has one of the Life Insureds:				
a) ever consulted a physician or other health care professional for a physical or mental disorder not already mentioned, or are they taking medication?	☐	☐	☐	☐
b) within the last five (5) years, had an electrocardiogram, x-ray, mammogram, blood tests or other diagnostic tests, surgery or been hospitalized?	☐	☐	☐	☐
19) Has one of the Life Insureds ever suffered from, had symptoms or complained about a health problem, for which they have not yet consulted a physician, or been advised to undergo tests or surgery that have not yet taken place?	☐	☐	☐	☐
20) Within the past five (5) years, has one of the Life Insureds undergone or been advised to undergo laboratory tests to detect the presence of the AIDS virus, AIDS antibodies or a sexually transmitted disease (STD); ever had, been told or received treatment for positive HIV test.	☐	☐	☐	☐

EXPLANATION DETAILS

No.	Name of Person	Illness, diagnosis, surgery, consultation, treatment, medication, results, date of last epilepsy seizure, asthma or other important information	Date			Duration		Name and address of physicians, including speciality, or hospitals (indicating if treated in hospital, out-patient clinic or physician's office).
			D	M	Y	Illness Days	Hospitalization Days	

SECTION D - FINANCIAL STATUS OF BUSINESS (COMPLETE THIS PART FOR BUSINESS INSURANCE)

Type of business:	Purpose of insurance:	Percentage of ownership held by each Life insured:

	Last Year	Previous Year		Last Year	Previous Year
Assets			Sales		
Liabilities			Market Value		
Net Earnings					

Indicate the amount of business insurance in force or pending on other partners or officers.

NAME	% OWNERSHIP	IN FORCE	PENDING	COMPANY

SECTION E - REPRESENTATIVE INFORMATION

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

Application No. 000000

SECTION F - DECLARATIONS AND AUTHORIZATIONS

1. The **Policyowner** and the **Life Insured(s)** declare that all the answers to questions in this application are true and correct to the best of their knowledge and that all material information has been disclosed. The policyowner understands that the Representative is paid by commission.
2. Each Life Insured consents to the issue of the insurance on him / her.
3. If the Company accepts the Application with modifications, and refers to the modification in the Notice of Modification on this page of this Application, then the acceptance of the policy by the Policyowner ratifies this modification.
4. Any medical information obtained during the evaluation of this application may be disclosed to the personal physician named in Section C of this application relating to the person concerned.
5. A photographic copy of this authorization is as valid as the original.
6. In the processing of this application the Company may obtain reports, including motor-vehicle driving records on file with any government department or agency, covering information pertaining to each Life Insured's character general reputation, personal characteristics and mode of living. Each person to be insured consents to such records being obtained by the Company.
7. The policyowner and the proposed insureds acknowledge that any misrepresentation, including the misrepresentation of smoking habits, may void the policy.
8. The Company may give to its reinsurers and to other insurers any information about me that is relevant to determining my eligibility for insurance coverage or for benefits.
9. 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, only 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 establishement, the Medical Information Bureau, insurance companies, personal information brokers or investigation firms, the policyowner, and my employer or ex-employers.

Amount Paid with this Application for change, reinstatement or conversion $

Dated at	this	day of	year

Signature of Policyowner(s)

Signature of Insured 1

Signature of account holder(s) if not policyowner(s) and if premiums paid via pre-authorized cheque plan.

Signature of Insured 2

Signature of Witness / Representative

Signature of parent or legal guardian of minor children

NOTICE OF MODIFICATION (Head Office Use Only)

Desjardins Financial Security®

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Desjardins Financial Security Life Assurance Company
95 St. Clair Avenue West, Toronto ON M4V 1N7

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 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 Policyowner

X

Signature of Representative

X

Print Name of Representative

Desjardins Financial Security®

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Desjardins Financial Security Life Assurance Company
95 St. Clair Avenue West, Toronto ON M4V 1N7

PRIVACY STATEMENT

In order to issue a contract of insurance on your life or health, and to assess any claim arising from the policy, the Company must have access to confidential information about you.

We will keep personal information about you on file at our Head Office for the purpose of administering the contract, or other contracts arising from this one. We will restrict access to our files so that only employees, auditors or representatives who need to use the information have access to it.

These notices to be left with Life Insured / Policyowner

Upon receipt of your written request, we will permit you access to any personal information about you in the file unless legal proceedings are involved or anticipated. Similarly, on receipt of your written request, any information which is shown to be incorrect will be corrected.

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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.

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