

Policy number(s)	Policyowner	Social Insurance Number
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**Desjardins Financial Security Life Assurance Company (herein called the “Company”) is requested and authorized to do the following:**

**A- Transfer of Ownership Rights (This could result in a taxable policy gain)**

Surname	First Name	Date of Birth	Social Insurance Number
		DD   MM   YY	
Address	Street	Apt. No.	City
		Province	Postal Code
Relationship to Life Insured	Relationship to Former Policyowner	Telephone	
		Res.: ( )	Cell.: ( )
		Bus.: ( )	Ext.: ( )

**This transfer of ownership terminates the existing beneficiary designation. SECTION B MUST BE COMPLETED IN ALL CASES BY THE NEW OWNER.**  
**NOTE: Transfer of Ownership is not allowed on a registered policy.**

**B- Change of Beneficiary for Life Insurance and Savings**

Surname, First Name (Insured)	Surname, First Name (Beneficiary)	Sex	Date of Birth	Relationship to Insured	% Payable	Status
Insured	1 <sup>st</sup> Beneficiary	<input type="checkbox"/> M <input type="checkbox"/> F	DD   MM   YY	<input type="checkbox"/> married <input type="checkbox"/> civil union spouse <input type="checkbox"/> common-law spouse <input type="checkbox"/> other (specify) _____		<input type="checkbox"/> Revocable <input type="checkbox"/> Irrevocable
	2 <sup>nd</sup> Beneficiary	<input type="checkbox"/> M <input type="checkbox"/> F	DD   MM   YY	<input type="checkbox"/> married <input type="checkbox"/> civil union spouse <input type="checkbox"/> common-law spouse <input type="checkbox"/> other (specify) _____		<input type="checkbox"/> Revocable <input type="checkbox"/> Irrevocable
Insured	1 <sup>st</sup> Beneficiary	<input type="checkbox"/> M <input type="checkbox"/> F	DD   MM   YY	<input type="checkbox"/> married <input type="checkbox"/> civil union spouse <input type="checkbox"/> common-law spouse <input type="checkbox"/> other (specify) _____		<input type="checkbox"/> Revocable <input type="checkbox"/> Irrevocable
	2 <sup>nd</sup> Beneficiary	<input type="checkbox"/> M <input type="checkbox"/> F	DD   MM   YY	<input type="checkbox"/> married <input type="checkbox"/> civil union spouse <input type="checkbox"/> common-law spouse <input type="checkbox"/> other (specify) _____		<input type="checkbox"/> Revocable <input type="checkbox"/> Irrevocable
Insured	1 <sup>st</sup> Beneficiary	<input type="checkbox"/> M <input type="checkbox"/> F	DD   MM   YY	<input type="checkbox"/> married <input type="checkbox"/> civil union spouse <input type="checkbox"/> common-law spouse <input type="checkbox"/> other (specify) _____		<input type="checkbox"/> Revocable <input type="checkbox"/> Irrevocable
	2 <sup>nd</sup> Beneficiary	<input type="checkbox"/> M <input type="checkbox"/> F	DD   MM   YY	<input type="checkbox"/> married <input type="checkbox"/> civil union spouse <input type="checkbox"/> common-law spouse <input type="checkbox"/> other (specify) _____		<input type="checkbox"/> Revocable <input type="checkbox"/> Irrevocable

**For policies issued in Quebec, if you have named your spouse (married or civil union), the designation is irrevocable unless you select Revocable.**  
**For policies issued in all provinces except Quebec, all beneficiary designations are revocable unless you select Irrevocable.**

**C- Change of Beneficiary for Critical Illness and Health Insurance**

Type of Benefit	Surname, First Name (Insured)	Surname, First Name (Beneficiary)	Sex	Date of Birth	Relationship to Insured	% Payable	Status
Critical Illness Insurance Amount	Insured	1 <sup>st</sup> Beneficiary	<input type="checkbox"/> M <input type="checkbox"/> F	DD   MM   YY	<input type="checkbox"/> married <input type="checkbox"/> civil union spouse <input type="checkbox"/> common-law spouse <input type="checkbox"/> other (specify) _____		<input type="checkbox"/> Revocable <input type="checkbox"/> Irrevocable
		2 <sup>nd</sup> Beneficiary	<input type="checkbox"/> M <input type="checkbox"/> F	DD   MM   YY	<input type="checkbox"/> married <input type="checkbox"/> civil union spouse <input type="checkbox"/> common-law spouse <input type="checkbox"/> other (specify) _____		<input type="checkbox"/> Revocable <input type="checkbox"/> Irrevocable
Death Benefit	Insured	1 <sup>st</sup> Beneficiary	<input type="checkbox"/> M <input type="checkbox"/> F	DD   MM   YY	<input type="checkbox"/> married <input type="checkbox"/> civil union spouse <input type="checkbox"/> common-law spouse <input type="checkbox"/> other (specify) _____		<input type="checkbox"/> Revocable <input type="checkbox"/> Irrevocable
		2 <sup>nd</sup> Beneficiary	<input type="checkbox"/> M <input type="checkbox"/> F	DD   MM   YY	<input type="checkbox"/> married <input type="checkbox"/> civil union spouse <input type="checkbox"/> common-law spouse <input type="checkbox"/> other (specify) _____		<input type="checkbox"/> Revocable <input type="checkbox"/> Irrevocable
Health Benefit	Insured	1 <sup>st</sup> Beneficiary	<input type="checkbox"/> M <input type="checkbox"/> F	DD   MM   YY	<input type="checkbox"/> married <input type="checkbox"/> civil union spouse <input type="checkbox"/> common-law spouse <input type="checkbox"/> other (specify) _____		<input type="checkbox"/> Revocable <input type="checkbox"/> Irrevocable
		2 <sup>nd</sup> Beneficiary	<input type="checkbox"/> M <input type="checkbox"/> F	DD   MM   YY	<input type="checkbox"/> married <input type="checkbox"/> civil union spouse <input type="checkbox"/> common-law spouse <input type="checkbox"/> other (specify) _____		<input type="checkbox"/> Revocable <input type="checkbox"/> Irrevocable

**For policies issued in Quebec, if you have named your spouse (married or civil union), the designation is irrevocable unless you select Revocable.**  
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**D- Change of Beneficiary for Long Term Care Insurance**

Protection	Surname, First Name (Beneficiary)	Sex	Date of Birth	Relationship to Insured	% Payable	Status
Monthly Benefit	1 <sup>st</sup> Beneficiary	<input type="checkbox"/> M <input type="checkbox"/> F	DD   MM   YY	<input type="checkbox"/> married <input type="checkbox"/> civil union spouse <input type="checkbox"/> common-law spouse <input type="checkbox"/> other (specify) _____		<input type="checkbox"/> Revocable <input type="checkbox"/> Irrevocable
	2 <sup>nd</sup> Beneficiary	<input type="checkbox"/> M <input type="checkbox"/> F	DD   MM   YY	<input type="checkbox"/> married <input type="checkbox"/> civil union spouse <input type="checkbox"/> common-law spouse <input type="checkbox"/> other (specify) _____		<input type="checkbox"/> Revocable <input type="checkbox"/> Irrevocable
Refund Upon Death (If applicable)	1 <sup>st</sup> Beneficiary	<input type="checkbox"/> M <input type="checkbox"/> F	DD   MM   YY	<input type="checkbox"/> married <input type="checkbox"/> civil union spouse <input type="checkbox"/> common-law spouse <input type="checkbox"/> other (specify) _____		<input type="checkbox"/> Revocable <input type="checkbox"/> Irrevocable
	2 <sup>nd</sup> Beneficiary	<input type="checkbox"/> M <input type="checkbox"/> F	DD   MM   YY	<input type="checkbox"/> married <input type="checkbox"/> civil union spouse <input type="checkbox"/> common-law spouse <input type="checkbox"/> other (specify) _____		<input type="checkbox"/> Revocable <input type="checkbox"/> Irrevocable

**For policies issued in Quebec, if you have named your spouse (married or civil union), the designation is irrevocable unless you select Revocable.**  
**For policies issued in all provinces except Quebec, all beneficiary designations are revocable unless you select Irrevocable.**

<input type="checkbox"/> <b>E- Designation of a Trustee for a Minor Beneficiary</b>				
I hereby appoint the following person as trustee to receive the benefits payable to any beneficiary who has not reached legal age. This designation is revocable and applies until said beneficiary reaches legal age.				
Name of Trustee		Sex	Date of birth	Relationship to insured
Surname	First Name	<input type="checkbox"/> M <input type="checkbox"/> F	DD   MM   YY	

<input type="checkbox"/> <b>F- Appoint as Contingent</b>		<input type="checkbox"/> <b>Policyowner</b>	<input type="checkbox"/> <b>Beneficiary</b>
Surname	First Name	Sex	Date of birth
		<input type="checkbox"/> M <input type="checkbox"/> F	DD   MM   YY
Address		City	Province
		Postal Code	Telephone
			Res.: ( ) Bus.: ( ) ext.
<b>Contingent Policyowners and Contingent Beneficiaries have no policy rights until the death of the existing Policyowner or Beneficiary, respectively. Unless the Company states otherwise, by registering this document, the Company is agreeing to any changes of contingent policyowner it contains.</b>			

<input type="checkbox"/> <b>G- Assign the Policy for Collateral Purposes</b>				
Surname		First Name		Sex
				<input type="checkbox"/> M <input type="checkbox"/> F
Address		City	Province	Postal Code
				Telephone
				Res.: ( ) Bus.: ( ) ext.
This assignment does not terminate the existing beneficiary designation. The assignee shall be included as a joint payee on the payment of any policy proceeds. The interest of the assignee is limited to the amount required to satisfy the policyowner's obligation to him/her. The assignee shall have the right to surrender or borrow on the policy without the consent of the policyowner or beneficiary. Unless specifically requested in writing to do otherwise, the Company will make no changes in the notices respecting this policy.				

<input type="checkbox"/> <b>H- Change of Name</b>		<input type="checkbox"/> <b>Policyowner</b>	<input type="checkbox"/> <b>Life Insured</b>	<input type="checkbox"/> <b>Beneficiary</b>	<input type="checkbox"/> <b>Assignee</b>
Surname		First Name		Reason for change	Date of Marriage / Divorce
To:				<input type="checkbox"/> Marriage <input type="checkbox"/> Divorce	DD   MM   YY
<input type="checkbox"/> Correcting Error - Explain			<input type="checkbox"/> Legal - Explain and attach certified copies of legal documents		

<input type="checkbox"/> <b>I- Lost Policy Declaration</b>
I, the undersigned Policyowner, certify that the above policy has been lost. I request the issuance of a <input type="checkbox"/> policy certificate outlining major features of the policy <input type="checkbox"/> duplicate policy, where available, with appropriate fee

<input type="checkbox"/> <b>J- Signatures</b>	
I ask that Desjardins Financial Security Life Assurance Company make the change(s) indicated above, in accordance with the rights, conditions and stipulations of the contract.	
Current Policyowner _____	For Companies _____ Name and Title of Signing Officer in Block Letters
Joint Policyowner _____	For Companies _____ Name and Title of Signing Officer in Block Letters
New Policyowner _____	For Companies _____ Name and Title of Signing Officer in Block Letters
Irrevocable / Preferred Beneficiary _____	
Collateral Assignee _____	For Companies _____ Name and Title of Signing Officer in Block Letters
Witness _____	Signature _____
Dated at _____ this _____ day of _____ 20_____	