

DISABLED PERSON'S STATEMENT

Monthly benefit - Please attach your tax return for the 3 years immediately preceding the onset of disability
 Waiver of premium

A - IDENTIFICATION We are unable to assess this claim unless all questions are answered completely.

Disabled person's last name		Last name at birth		First name		Date of birth	
						Y M D	
Address						Postal Code	
Phone Nos. Home:		AREA CODE + NUMBER		Office:		AREA CODE + NUMBER	
Training				Level of education			
Name of first insured				F.C. No.		Representative No.	Contract No.

B - GENERAL INFORMATION

1. Date of first symptoms related to the current disability Y M D			2. Date of first visit to a physician for this illness or injury Y M D			
3. Was this an accident? <input type="checkbox"/> Yes <input type="checkbox"/> No			If "Yes", date of accident Y M D			
			Time <input type="checkbox"/> AM <input type="checkbox"/> PM	Type of accident <input type="checkbox"/> Work-related <input type="checkbox"/> Motor Vehicle <input type="checkbox"/> Other		
Specify where and how the accident occurred.						
4. What were your activities before the current disability?						
Domestic		Sports		Social and cultural		
5. Date on which you stopped working or performing your normal activities as a result of the illness or accident: Y M D						
6. Have you resumed your normal activities? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", since what date? Y M D						
7. Are you returned to full-time or part-time work? <input type="checkbox"/> Yes <input type="checkbox"/> No			8. Are you gainfully employed in another occupation? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Date of return to work Y M D			If "Yes", since what date? Y M D			
9. Are you currently a student? <input type="checkbox"/> Yes <input type="checkbox"/> No			No. of class hours per week:			
Date of return to work Y M D			If "Yes", since what date? Y M D			
10. Describe the kind of treatment that you are presently receiving (physiotherapy, medication or other). For each one, specify the number of times per day, per week or per month that you receive these treatments.						
11. Name of your personal physician Since what date? Y M D						
12. Have you consulted a physician or a health care professional or have been hospitalized for one or more medical reasons over the 5 years preceding your current disability? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", complete the table:						
Name of physicians or health care professionals who treated you		Type of illness or injury	Date of consultations	Name of hospitals where you were treated		
				Hospitalization periods		
				FROM: TO:		
				FROM: TO:		
13. Prior this disability, have you taken any medication during the last 5 years? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", complete the table:						
Illnesses		Name of medication		Periods		
				FROM: TO:		
				FROM: TO:		
14. a) Are you a smoker or a former smoker? <input type="checkbox"/> Yes <input type="checkbox"/> No		b) When did you start smoking? D M Y	c) When did you stop smoking? D M Y	d) Specify non-smoking periods.		
15. Have you had more than one employer or have you been self-employed over the last 5 years? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", complete the table:						
Name and address of employers (if applicable)		Duration of employment		Type of work		
		FROM: TO:				
		FROM: TO:				
16. If a claim for the same illness or accident has been submitted to Desjardins Financial Security Life Assurance Company under another contract, please specify:						
		Type of insurance		Contract, policy or certificate No.		
17. (a) Have you filed a claim with a government agency or another company? If "Yes", attach the notice of approval or rejection.						
		Yes No	Date filed	Was your application approved?	Monthly amount	Payment period (if limited)
<input type="checkbox"/> QPP <input type="checkbox"/> CPP		<input type="checkbox"/> <input type="checkbox"/>	Y M D	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Processed		
Société de l'assurance automobile du Québec		<input type="checkbox"/> <input type="checkbox"/>	Y M D	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Processed		
CSST or any other similar organization		<input type="checkbox"/> <input type="checkbox"/>	Y M D	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Processed		
Pension Plan (pension fund)		<input type="checkbox"/> <input type="checkbox"/>	Y M D	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Processed		
Other insurance: <input type="checkbox"/> individual <input type="checkbox"/> group		<input type="checkbox"/> <input type="checkbox"/>	Y M D	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Processed		
Name of companies and contract nos.:						
(b) Do you have other sources of income? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", specify: Weekly amount: _____						
<input type="checkbox"/> Holiday pay <input type="checkbox"/> Maternity <input type="checkbox"/> Sick leave <input type="checkbox"/> Salary <input type="checkbox"/> EI benefits <input type="checkbox"/> Lump sum <input type="checkbox"/> Other:						
(c) <input type="checkbox"/> I do not and I do not expect to receive disability benefits from the organizations listed above. However, if I subsequently receive disability benefits from any of these organizations, I will inform you.						

DECLARATION - I hereby certify that the above answers are full and true. I acknowledge that I have read the notice regarding the opening of a personal information file on the reverse side of this form.

SIGNATURE OF DISABLED PERSON X DATE

C - AUTHORIZATION FOR THE COLLECTION AND COMMUNICATION OF PERSONAL INFORMATION

To be completed for each claim
 I authorize Desjardins Financial Security Life Assurance Company, strictly for the purposes of determining my insurability, managing my file and settling my claims to: (a) collect from any person or legal entity, or from any public or parapublic organization, only the information deemed necessary to manage my file. The non-exhaustive list of sources from which information may be collected includes health care professionals or facilities, the MIB, insurance companies, personal information officers or investigation agencies, the policyholder, my employer or former employers; (b) communicate to the said persons or organizations only the personal information about me that is deemed necessary for the purposes of my file; (c) when necessary, request an inquiry report about me, and also use the personal information it may have about me in existing files that are now closed. A photocopy of this authorization is as valid as the original.

SIGNATURE OF DISABLED PERSON X DATE

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

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.