

Table of contents

Part 1

Choice of contract format.....	1
A - General information.....	1
B - Beneficiary information.....	5
C - Type and amount of insurance applied for.....	8
D - Request for change.....	8
E - Eligibility.....	11

Part 2

F - Insurability statement.....	15
G - Special instructions.....	26

Part 3

H - Paying for the insurance.....	27
I - Provisional or conditional insurance.....	33
J - Notice applicable to MIB, LLC.....	39
K - Consent related to the management of your personal information by Desjardins Group.....	43
L - Consent related to the management of your personal information by Desjardins Insurance.....	45
M - Consent to disclose supplementary personal information to the representative.....	47
N - Statements and authorizations.....	48
O - Specific consent.....	52
P - Representative information and declaration.....	54

Referrals	Addendum
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200, rue des Commandeurs
Lévis (Québec) G6V 6R2
1, Complexe Desjardins
Montréal (Québec) H5B 1E2

Phone: 1-800-278-0669

Important information and instructions

1. Before submitting this insurance application to Desjardins Insurance's Head Office, please ensure you have provided all the required information. An incomplete application will delay processing.
2. Use this application when applying for life (traditional and universal), disability, critical illness or health insurance, or to request a change that requires evidence of insurability.
Note: A proposed insured can apply for SOLO Disability Income and/or SOLO Loan Insurance on the same application. If more than one proposed insured is applying for SOLO Disability Income and/or SOLO Loan Insurance, a separate application must be completed for each person.
3. **Do not** use this application for any request for change without evidence of insurability.
4. Ask all the questions in the application that apply to your client and record the answers completely and accurately. **Please ensure all required signatures have been obtained on pages 44, 46, 47, 49, 50, 52 and 54.**
5. Print legibly, preferably in black ink, for photocopying purposes. Do not use ditto marks or liquid paper. Do not erase. If you have a correction to make, strike out the error and have the client initial it.
6. **Ensure the latest version of the illustration software is used to illustrate the elected insurance.** The illustration must be submitted with this application. For universal and participating life coverages, the "Illustration Acknowledgement and Signatures" must also be signed by the policyowner and submitted with the application.
7. You must give a copy of the **Notice applicable to MIB, LLC:**
 - To each proposed insured age **14 or older** (Quebec) or **16 or older** (provinces or territories other than Quebec).
 - To the parent, guardian or legal representative of each proposed insured **under age 14** (Quebec) or **under age 16** (provinces or territories other than Quebec).

A - General information (cont.)

Please complete this section if the proposed insureds and policyowners are age 18 or older and life or critical illness insurance coverages are requested.

<input type="checkbox"/> Insured 1 only	<input type="checkbox"/> Insured 1 and policyowner 1	<input type="checkbox"/> Insured 2 only	<input type="checkbox"/> Insured 2 and policyowner 2
Personal net worth in Canada	CAN\$	Personal net worth in Canada	CAN\$
Personal net worth abroad	CAN\$	Personal net worth abroad	CAN\$

- i** Net worth = Assets minus liabilities
- Assets: What you have (liquid assets, personal property, savings, investments, RRSPs, etc.)
 - Liabilities: What you owe (mortgages, lines of credit, personal loans, credit card balances, etc.)

A2 - Identification of a policyowner who is not a proposed insured

- If there is more than 1 policyowner without coverage, provide the personal details shown below in **section G - Special instructions**.

Policyowner – Individual

First name		Last name	
Date of birth (yyyy/mm/dd)	Sex <input type="checkbox"/> Female <input type="checkbox"/> Male	Email	Specific occupation (e.g., building engineer)
Address (No., street, apt.) <input type="checkbox"/> same address as Insured 1			City
Province or territory	Postal code	Do you speak and understand English? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please specify your language: _____	
10-digit phone number Home: _____ Cell.: _____		Who is explaining the contents of this application to you in your language? (Note: This person cannot be a policyowner or a beneficiary named in the application.) <input type="checkbox"/> Your representative <input type="checkbox"/> Another person – please identify this person below:	
Work: _____, ext.: _____		First name	Last name
		Relationship to you	

Please complete this section if the policyowner is age 18 or older and life or critical illness insurance coverages are requested.

Personal net worth in Canada	CAN\$
Personal net worth abroad	CAN\$

- i** Net worth = Assets minus liabilities
- Assets: What you have (liquid assets, personal property, savings, investments, RRSPs, etc.)
 - Liabilities: What you owe (mortgages, lines of credit, personal loans, credit card balances, etc.)

Policyowner – Corporation, trust or other entity (e.g., Health Priorities - Business, SOLO Loan Insurance)

i Note: Please fill out form **08295E** for life insurance contracts with cash surrender values or a savings component.

Federal business number (all provinces and territories)	Provincial business number (Quebec only)	or	Federal trust number (all provinces and territories)	Provincial trust number (Quebec only)
_____	_____		_____	_____

Important: If the business or trust number is missing, the policyowner must provide it to Desjardins Insurance within **90 days**.

Company name			
Address (No., street, apt.)	City	Province or territory	Postal code
Email	10-digit phone number _____, ext.: _____		

Does the business carry out activities related to the cannabis industry (cultivation, processing, sales or other related activities)? Yes No

If **yes:** Any business that carries out activities related to the cannabis industry must have a **licence from Health Canada**. In some cases, a **licence from the Canada Revenue Agency** is also required.

Important: You must provide us with a copy of your **valid licence(s)** within **90 days** of signing your Application for Insurance, otherwise we won't be able to review your application.

A - General information (cont.)

A3 - Identification of the authorized signatory and documents to provide

- For a corporation, trust or other entity policyowner: Please attach the documents granting the signatory identified below the authorization to act (for example, a power of attorney or company resolution).
- For a person of major age who has been declared legally incapable (policyowner or proposed insured): Please attach the legal documents that confirm this person's incapacity and that grant the signatory identified below the authorization to act. **Note:** You don't need to fill out the **Specific occupation** field for this signatory.

First Name	Last Name	Specific occupation (e.g., building engineer)
Address (No., street, apt.)		
City	Province or territory	Postal code

A4 - Declaration of tax residence (Policyowner – Individual)

i To be completed if applying for a life insurance coverage with cash surrender values or a savings component.

i If the policyowner is a corporation, trust or other entity, please fill out form **08295E** for the declaration of tax residence.

For more information, please refer to the documents on [web](#).

Note: If there are more than 2 policyowners, provide the details shown below in **section G – Special instructions**.

Check all the options that apply to your situation and provide all the requested information. If your declaration is not completed properly, we will not be able to analyze your insurance application.

<p>Policyowner completing the declaration:</p> <p><input type="checkbox"/> Policyowner 1 identified in section A1</p> <p><input type="checkbox"/> Policyowner identified in section A2</p>	<p>Policyowner completing the declaration:</p> <p><input type="checkbox"/> Policyowner 2 identified in section A1</p> <p><input type="checkbox"/> Policyowner identified in section A2</p>												
<p><input type="checkbox"/> I am a tax resident of Canada.</p>	<p><input type="checkbox"/> I am a tax resident of Canada.</p>												
<p><input type="checkbox"/> I am a tax resident or a citizen of the United States.</p> <p>a) If you check this box, provide your U.S. Taxpayer Identification Number (TIN):</p> <p>_____</p> <p>b) If you do not have a TIN, have you applied for one?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>c) If you have a Canadian social insurance number (SIN), or if you had one in the past, you are required to enter it:</p> <p>_____</p> <p><input type="checkbox"/> I do not have a Canadian SIN.</p>	<p><input type="checkbox"/> I am a tax resident or a citizen of the United States.</p> <p>a) If you check this box, provide your U.S. Taxpayer Identification Number (TIN):</p> <p>_____</p> <p>b) If you do not have a TIN, have you applied for one?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>c) If you have a Canadian social insurance number (SIN), or if you had one in the past, you are required to enter it:</p> <p>_____</p> <p><input type="checkbox"/> I do not have a Canadian SIN.</p>												
<p><input type="checkbox"/> I am a tax resident of one or more countries other than Canada or the United States.</p> <p>a) If you check this box, provide your countries of tax residence and Taxpayer Identification Numbers (TIN).</p> <table border="1"> <thead> <tr> <th>Country of tax residence</th> <th>TIN</th> </tr> </thead> <tbody> <tr> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> </tr> </tbody> </table> <p>b) If you do not have a TIN, explain why by checking one of the following boxes:</p> <p><input type="checkbox"/> I will apply or have applied for a TIN but have not yet received it.</p> <p><input type="checkbox"/> My country of tax residence does not issue TINs to its residents.</p> <p><input type="checkbox"/> Other reason (explain): _____</p> <p>c) If you have a Canadian social insurance number (SIN), or if you had one in the past, you are required to enter it:</p> <p>_____</p> <p><input type="checkbox"/> I do not have a Canadian SIN.</p>	Country of tax residence	TIN	_____	_____	_____	_____	<p><input type="checkbox"/> I am a tax resident of one or more countries other than Canada or the United States.</p> <p>a) If you check this box, provide your countries of tax residence and Taxpayer Identification Numbers (TIN).</p> <table border="1"> <thead> <tr> <th>Country of tax residence</th> <th>TIN</th> </tr> </thead> <tbody> <tr> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> </tr> </tbody> </table> <p>b) If you do not have a TIN, explain why by checking one of the following boxes:</p> <p><input type="checkbox"/> I will apply or have applied for a TIN but have not yet received it.</p> <p><input type="checkbox"/> My country of tax residence does not issue TINs to its residents.</p> <p><input type="checkbox"/> Other reason (explain): _____</p> <p>c) If you have a Canadian social insurance number (SIN), or if you had one in the past, you are required to enter it:</p> <p>_____</p> <p><input type="checkbox"/> I do not have a Canadian SIN.</p>	Country of tax residence	TIN	_____	_____	_____	_____
Country of tax residence	TIN												
_____	_____												
_____	_____												
Country of tax residence	TIN												
_____	_____												
_____	_____												

A - General information (cont.)
A5 - Verification of policyowner identity (Individual)

Policyowner whose identity is being verified: <input type="checkbox"/> Policyowner 1 identified in section A1 <input type="checkbox"/> Policyowner identified in section A2		Policyowner whose identity is being verified: <input type="checkbox"/> Policyowner 2 identified in section A1 <input type="checkbox"/> Policyowner identified in section A2	
<input type="checkbox"/> Health insurance card* <input type="checkbox"/> Passport <input type="checkbox"/> Provincial identity card <input type="checkbox"/> Other photo card issued by a government	<input type="checkbox"/> Driver's licence <input type="checkbox"/> Canadian citizenship card/certificate <input type="checkbox"/> Permanent resident card	<input type="checkbox"/> Health insurance card* <input type="checkbox"/> Passport <input type="checkbox"/> Provincial identity card <input type="checkbox"/> Other photo card issued by a government	<input type="checkbox"/> Driver's licence <input type="checkbox"/> Canadian citizenship card/certificate <input type="checkbox"/> Permanent resident card
* Cards issued in Manitoba, Ontario, Nova Scotia and Prince Edward Island are not valid for identification purposes.		* Cards issued in Manitoba, Ontario, Nova Scotia and Prince Edward Island are not valid for identification purposes.	
Place of issue		Place of issue	
Province, territory or state: _____		Province, territory or state: _____	
Country: _____		Country: _____	
Expiry date (yyyy/mm/dd) <small>(an expired ID is not valid)</small>	Date ID checked (yyyy/mm/dd)	Expiry date (yyyy/mm/dd) <small>(an expired ID is not valid)</small>	Date ID checked (yyyy/mm/dd)

Fill out the following section if life insurance coverage with cash surrender values or a savings component is applied for.

Number of the ID selected above	Number of the ID selected above
If the identity is being checked remotely, the policyowner must also show one of the following documents to confirm their name and address: <input type="checkbox"/> Utility bill <input type="checkbox"/> Employment Insurance benefit statement <input type="checkbox"/> Statement of Old Age Security <input type="checkbox"/> Statement of Canada Pension Plan Benefits <input type="checkbox"/> Bank or credit card statement (the statement must not be issued by a caisse or entity of Desjardins Group) <input type="checkbox"/> Other document from a reliable source that contains the policyowner's name and address: _____	If the identity is being checked remotely, the policyowner must also show one of the following documents to confirm their name and address: <input type="checkbox"/> Utility bill <input type="checkbox"/> Employment Insurance benefit statement <input type="checkbox"/> Statement of Old Age Security <input type="checkbox"/> Statement of Canada Pension Plan Benefits <input type="checkbox"/> Bank or credit card statement (the statement must not be issued by a caisse or entity of Desjardins Group) <input type="checkbox"/> Other document from a reliable source that contains the policyowner's name and address: _____
Name of issuer	Name of issuer
Account or reference number	Account or reference number
Date of issue (yyyy/mm/dd)	Date of issue (yyyy/mm/dd)

A6 - Verification of authorized signatory identity (Corporation, trust or other entity / policyowner of major age who has been declared legally incapable)

i The identity of the authorized signatory must be verified using form 08295E if:

- the policyowner is a corporation, trust or other entity; and
- life insurance coverage with cash surrender values or a savings component is applied for.

<input type="checkbox"/> Health insurance card* <input type="checkbox"/> Provincial identity card	<input type="checkbox"/> Driver's licence <input type="checkbox"/> Permanent resident card	<input type="checkbox"/> Passport <input type="checkbox"/> Other photo card issued by a government	<input type="checkbox"/> Canadian citizenship card/certificate
* Cards issued in Manitoba, Ontario, Nova Scotia and Prince Edward Island are not valid for identification purposes.			
Place of issue	Expiry date (yyyy/mm/dd) <small>(an expired ID is not valid)</small>	Date ID checked (yyyy/mm/dd)	
Province, territory or state: _____			
Country: _____			

A7 - Contingent policyowner

- Upon the death of any policyowner, their rights and interests in the contract will be transferred to:

<input type="checkbox"/> The surviving policyowner (applies only if there is more than one policyowner)		<input type="checkbox"/> The contingent policyowner named below	
First name		Last name	
Date of birth (yyyy/mm/dd)	Sex <input type="checkbox"/> Female <input type="checkbox"/> Male	10-digit phone number	
Address (No., street, apt.) <input type="checkbox"/> same address as Insured 1	City	Province or territory	Postal code

A - General information (cont.)
A8 - Company's financial position

Please complete this section and provide financial statements if the insurance elected is considered business insurance (for a partnership, key person or business loan, for example) and if any of the following situations apply:

- The total life insurance amount in force, including current amount applied for, is **greater than \$500,000**.
- The total critical illness insurance amount in force, including current amount applied for, is **greater than \$250,000**.
- You are requesting an Additional Deposit Option for participating life insurance, regardless of the amount of basic life insurance.

Nature of company	Percentage owned by Insured 1 %	Percentage owned by Insured 2 %		
Information about the policyowner's company	Last year	Prior to last year		
Assets	\$	\$		
Liabilities	\$	\$		
Net earnings	\$	\$		
Sales figures	\$	\$		
Market value	\$	\$		
Purpose of insurance:	Financial year-end (yyyy/mm/dd):			
Insurance on other partners or officers (include insurance in force or pending)				
Name of partners or officers	Ownership%	In force	Pending	Insurance company
		\$	\$	
		\$	\$	

B - Beneficiary information
B1 - Death

 If a contract includes Health Priorities - Business coverage, complete **section B4 - Health Priorities - Business only**.

Instructions: Please name the beneficiaries of all amounts payable in the event the insured dies.

E.g., life insurance benefit, premium refund, death benefit not included in a life insurance coverage

- The insured's beneficiary percentages must add up to 100%.
- If you need more space, use **section G - Special instructions**.

Beneficiaries for Insured 1	%	Date of birth (yyyy/mm/dd)	Relationship between the beneficiary and: - the policyowner , for contracts issued in Quebec - the proposed insured , for contracts issued in provinces or territories other than Quebec	Sex	Status
First name			<input type="checkbox"/> Married <input type="checkbox"/> Civil union spouse (Quebec only) <input type="checkbox"/> Common-law spouse <input type="checkbox"/> Other:	<input type="checkbox"/> F <input type="checkbox"/> M	<input type="checkbox"/> Revocable <input type="checkbox"/> Irrevocable
Last name					
First name			<input type="checkbox"/> Married <input type="checkbox"/> Civil union spouse (Quebec only) <input type="checkbox"/> Common-law spouse <input type="checkbox"/> Other:	<input type="checkbox"/> F <input type="checkbox"/> M	<input type="checkbox"/> Revocable <input type="checkbox"/> Irrevocable
Last name					
Beneficiaries for Insured 2					
First name			<input type="checkbox"/> Married <input type="checkbox"/> Civil union spouse (Quebec only) <input type="checkbox"/> Common-law spouse <input type="checkbox"/> Other:	<input type="checkbox"/> F <input type="checkbox"/> M	<input type="checkbox"/> Revocable <input type="checkbox"/> Irrevocable
Last name					
First name			<input type="checkbox"/> Married <input type="checkbox"/> Civil union spouse (Quebec only) <input type="checkbox"/> Common-law spouse <input type="checkbox"/> Other:	<input type="checkbox"/> F <input type="checkbox"/> M	<input type="checkbox"/> Revocable <input type="checkbox"/> Irrevocable
Last name					

B - Beneficiary information (cont.)


B2 - Designation of contingent beneficiaries

- If a beneficiary named in **section B1 - Death** dies before the insured, the contingent beneficiary named below will replace that beneficiary.

Beneficiary for Insured 1	Date of birth (yyyy/mm/dd)	Relationship between the beneficiary and: - the policyowner, for contracts issued in Quebec - the proposed insured, for contracts issued in provinces or territories other than Quebec	Sex	Status
First name		<input type="checkbox"/> Married <input type="checkbox"/> Civil union spouse (Quebec only) <input type="checkbox"/> Common-law spouse <input type="checkbox"/> Other:	<input type="checkbox"/> F <input type="checkbox"/> M	<input type="checkbox"/> Revocable <input type="checkbox"/> Irrevocable
Last name				

Beneficiary for Insured 2	Date of birth (yyyy/mm/dd)	Relationship between the beneficiary and: - the policyowner, for contracts issued in Quebec - the proposed insured, for contracts issued in provinces or territories other than Quebec	Sex	Status
First name		<input type="checkbox"/> Married <input type="checkbox"/> Civil union spouse (Quebec only) <input type="checkbox"/> Common-law spouse <input type="checkbox"/> Other:	<input type="checkbox"/> F <input type="checkbox"/> M	<input type="checkbox"/> Revocable <input type="checkbox"/> Irrevocable
Last name				

B3 - Critical illness

-  If a contract includes Health Priorities - Business coverage, complete **section B4 - Health Priorities - Business only**.

Instructions: Please name the beneficiaries of all amounts payable in the event the insured has a critical illness covered under a coverage of the contract.
E.g., amount of insurance or advance payable under a critical illness coverage

- The insured's beneficiary percentages must add up to 100%.
- If you need more space, use **section G - Special instructions**.

Beneficiaries for Insured 1	%	Date of birth (yyyy/mm/dd)	Relationship between the beneficiary and: - the policyowner, for contracts issued in Quebec - the proposed insured, for contracts issued in provinces or territories other than Quebec	Sex	Status
First name			<input type="checkbox"/> Married <input type="checkbox"/> Self <input type="checkbox"/> Civil union spouse (Quebec only) <input type="checkbox"/> Common-law spouse <input type="checkbox"/> Other:	<input type="checkbox"/> F <input type="checkbox"/> M	<input type="checkbox"/> Revocable <input type="checkbox"/> Irrevocable
Last name					
First name			<input type="checkbox"/> Married <input type="checkbox"/> Self <input type="checkbox"/> Civil union spouse (Quebec only) <input type="checkbox"/> Common-law spouse <input type="checkbox"/> Other:	<input type="checkbox"/> F <input type="checkbox"/> M	<input type="checkbox"/> Revocable <input type="checkbox"/> Irrevocable
Last name					

Beneficiaries for Insured 2	%	Date of birth (yyyy/mm/dd)	Relationship between the beneficiary and: - the policyowner, for contracts issued in Quebec - the proposed insured, for contracts issued in provinces or territories other than Quebec	Sex	Status
First name			<input type="checkbox"/> Married <input type="checkbox"/> Self <input type="checkbox"/> Civil union spouse (Quebec only) <input type="checkbox"/> Common-law spouse <input type="checkbox"/> Other:	<input type="checkbox"/> F <input type="checkbox"/> M	<input type="checkbox"/> Revocable <input type="checkbox"/> Irrevocable
Last name					
First name			<input type="checkbox"/> Married <input type="checkbox"/> Self <input type="checkbox"/> Civil union spouse (Quebec only) <input type="checkbox"/> Common-law spouse <input type="checkbox"/> Other:	<input type="checkbox"/> F <input type="checkbox"/> M	<input type="checkbox"/> Revocable <input type="checkbox"/> Irrevocable
Last name					

B - Beneficiary information (cont.)
B4 - Health Priorities - Business

Instructions: If the beneficiary of the **critical illness benefit** and **death benefit** is a corporation, you do not need to indicate the relationship between this beneficiary and the policyowner/insured. **However**, if the beneficiary is an individual, please indicate the relationship between this beneficiary and the second policyowner (individual) if the contract was issued in Quebec. If the contract was issued outside Quebec, please indicate the relationship between this beneficiary and the insured.

- The insured's beneficiary percentages must add up to 100%.
- If you need more space, use **section G - Special instructions**.

Critical illness benefit		
Beneficiaries	%	Status
Name		<input type="checkbox"/> Revocable <input type="checkbox"/> Irrevocable
Name		<input type="checkbox"/> Revocable <input type="checkbox"/> Irrevocable

Death benefit		
Beneficiaries	%	Status
Name		<input type="checkbox"/> Revocable <input type="checkbox"/> Irrevocable
Name		<input type="checkbox"/> Revocable <input type="checkbox"/> Irrevocable

Health benefit					
Beneficiaries	%	Date of birth (yyyy/mm/dd)	Relationship between the beneficiary and: - the policyowner, for contracts issued in Quebec - the proposed insured, for contracts issued in provinces or territories other than Quebec	Sex	Status
First name			<input type="checkbox"/> Married <input type="checkbox"/> Self <input type="checkbox"/> Civil union spouse (Quebec only) <input type="checkbox"/> Common-law spouse <input type="checkbox"/> Other:	<input type="checkbox"/> F <input type="checkbox"/> M	<input type="checkbox"/> Revocable <input type="checkbox"/> Irrevocable
Last name					
First name			<input type="checkbox"/> Married <input type="checkbox"/> Self <input type="checkbox"/> Civil union spouse (Quebec only) <input type="checkbox"/> Common-law spouse <input type="checkbox"/> Other:	<input type="checkbox"/> F <input type="checkbox"/> M	<input type="checkbox"/> Revocable <input type="checkbox"/> Irrevocable
Last name					

B5 - Designation of a trustee for a minor beneficiary (provinces or territories other than Quebec)

- To be completed for contracts issued outside Quebec only.
- If a minor beneficiary is named in **sections B1 - Death** and **B3 - Critical illness**, a trustee may be named for that beneficiary. The trustee must have reached the age of majority.

Beneficiaries for Insured 1	Trustee	Trustee's date of birth (yyyy/mm/dd)	Relationship between the trustee and the beneficiary	Sex
First name	First name			<input type="checkbox"/> F <input type="checkbox"/> M
Last name	Last name			
First name	First name			<input type="checkbox"/> F <input type="checkbox"/> M
Last name	Last name			

Beneficiaries for Insured 2				
Beneficiaries for Insured 2	Trustee	Trustee's date of birth (yyyy/mm/dd)	Relationship between the trustee and the beneficiary	Sex
First name	First name			<input type="checkbox"/> F <input type="checkbox"/> M
Last name	Last name			
First name	First name			<input type="checkbox"/> F <input type="checkbox"/> M
Last name	Last name			

C - Type and amount of insurance applied for

- Illustration (Head Office copy and underwriting requirements) must be submitted with the insurance application.
- For universal and participating life coverages, the "Illustration Acknowledgement and Signatures" must also be signed by the policyowner and submitted with the application.
- For SOLO disability coverages, please indicate the waiting period and the benefit period.

Insured 1		Insured 2	
Product	Insurance Amount	Product	Insurance Amount
	\$		\$
	\$		\$
	\$		\$
	\$		\$
	\$		\$
	\$		\$
Additional coverages:		Additional coverages:	

- Individual
 Joint first-to-die
 Joint last-to-die
 Joint last-to-die, paid-up first death

Speciality group

The distribution of the accumulated fund value (universal life) will be 100% on payment of death benefit (default option).

- Other options:
 100% upon first death
 Variable upon each death, specify: _____

For Participating Whole Life coverage (select dividend option / add Additional Deposit Option)

- Enhanced insurance – lifetime guarantee
 Paid-up additions
 Annual premium reduction
 Enhanced insurance – 10-year guarantee
 Dividends on deposit
 Cash payment
 Additional Deposit Option (ADO)
 Indicate the amount of the permitted annual deposit on an **annual basis only**: \$ _____

D - Request for change

- Any change below requires completion of **part 2, section F - Evidence of insurability** and any applicable sections in **parts 1 and 3**.
- For any request for change without evidence of insurability, please use form **09219E**.
- Contracts will be grandfathered when change requests are received. In some cases, a new contract will have to be issued.

Possible changes

Check the appropriate box for all products except SOLO disability coverages.

- Add insureds or coverages
 Change from regular to preferred rates
 Partial replacement
 Review an exclusion or extra premium
 Replacement within same contract
 Add or modify the Additional Deposit Option (ADO) – To determine which form you need to fill out (07002E or 24311E), please refer to the **In-force administration** page on [web](#).
 Other: _____

D - Request for change (cont.)

Check the appropriate box for changes to SOLO disability coverages only.

- | | |
|---|--|
| <input type="checkbox"/> Add rider | <input type="checkbox"/> Occupation class change |
| <input type="checkbox"/> Benefit period increase | <input type="checkbox"/> Occupation class upgrade ¹ |
| <input type="checkbox"/> Change from regular to preferred rates | <input type="checkbox"/> Review an exclusion or extra premium |
| <input type="checkbox"/> Change premium structure from T65 to T10 | <input type="checkbox"/> Waiting period reduction |
| <input type="checkbox"/> Monthly income benefit increase | <input type="checkbox"/> Other: _____ |

¹ **For occupation class upgrade requests only:** Do not use this application if the contract has been in force for 5 years or less. Instead, fill out the Request for Change Without Evidence form (09219E).

Description of the changes requested for Insured 1	Insurance amount / Permitted annual deposit (ADO) ²	
	From	To

² Please be sure to indicate the amount of the deposit on an **annual** basis.

Description of the changes requested for Insured 2	Insurance amount / Permitted annual deposit (ADO) ²	
	From	To

² Please be sure to indicate the amount of the deposit on an **annual** basis.



Desjardins Insurance refers to Desjardins Financial Security Life Assurance Company.

E - Eligibility

E1 - Eligibility for SOLO disability coverages

i A proposed insured can apply for SOLO Disability Income and/or SOLO Loan Insurance in this section. If more than one proposed insured is applying for SOLO Disability Income and/or SOLO Loan Insurance, a separate application must be completed for each person.

- For SOLO Disability Income, please complete **questions 1 to 20**.
- For SOLO Loan Insurance, please complete **questions 1 to 14**. If you are asking for an occupation class upgrade, also complete **question 15**.
- For SOLO Healthcare, complete **section E2** only.

Person who will be the SOLO Loan Insurance policyowner: **Policyowner 1** identified in **section A1** **Policyowner 2** identified in **section A1**
 Policyowner identified in **section A2** (Individual) Policyowner identified in **section A2** (Corporation, trust or other entity)

Specific situation

1- a) If you are a woman, are you pregnant? Yes No

If **yes**, specify your due date (yyyy/mm/dd): _____

b) Are you on precautionary cessation of work? Yes No

If **yes**, you are only eligible for SOLO Loan Insurance.

Complete **section E1** based on your employment situation before your precautionary cessation of work.

2- Are you on parental leave? Yes No

If **yes**, you are only eligible for SOLO Loan Insurance.

Complete **section E1** based on your employment situation before your parental leave.

3- Are you eligible to receive benefits from Employment Insurance (EI)? Yes No

Employment profile

4- Profession or occupation

5- Level of education

- High school Trade/Apprenticeship/Vocational College/CEGEP University
 None Other, specify: _____

6- Date you began working in your current occupation (yyyy/mm/dd):

If less than 3 years, indicate previous occupation:

7- **Responsibilities and duties** - Indicate the percentage of your time spent on each type of responsibility and **list the specific activities** involved in the "Duties" column.

Responsibilities	Percentage	Duties
a) Manual/physical		
b) Management/office work		
c) Supervision		
d) Others, specify:		
TOTAL:	100%	

8- Number of hours worked per week: _____

9- Number of weeks worked per year: _____ weeks/year

10- Do you work from home? Yes No

If **yes**, answer the following questions:

a) Indicate the percentage of work you do from home in a year: _____%

b) If you have regular clients, do they go to your home each week to receive your services? Yes No

c) **After deducting employment expenses**, did you earn an annual income of at least \$50,000 in each of the last 2 years? Yes No

11- Do you have any other part-time or full-time work?

Yes No

If **yes**, indicate:

a) Exact nature of your responsibilities: _____

b) Number of hours worked per week: _____

E - Eligibility (cont.)

E1 - Eligibility for SOLO disability coverages (cont.)

Company/employer profile

12- Name of company

13- Address (No., street, apt.)	City	Province or territory	Postal code
---------------------------------	------	-----------------------	-------------

14- a) Since when have you worked for this employer or been self-employed (yyyy/mm/dd)? _____

b) Please indicate your current employment situation:

- Employee
- Self-employed worker
- Business owner

c) If you are a business owner, please complete the table below:

Number of full-time employees (excluding owners):		Percentage of shares held in the company:	%
---	--	---	---

Insurable net annual earned income profile (earned income after overhead expenses but before taxes)

15- Earned income based on your current employment situation

a) <input type="checkbox"/> Employee Earned income is the amount reported on T1 Federal Tax Return: line 10100 plus line 10400, minus line 22900.	Annual income	Annual income (last year)	Annual income (prior to last year)
	\$	\$	\$
b) <input type="checkbox"/> Self-employed worker c) <input type="checkbox"/> Partners Earned income is the net income reported on your T1 Federal Tax Return: lines 13500 to 14300 - the income to date is the income for the current fiscal year.	Income to date (current year)	Total income (last year)	Total income (prior to last year)
	\$	\$	\$
d) <input type="checkbox"/> Owner of a business corporation/corporation (Inc.) Earned income is the amount reported on your T1 Federal Tax Return: line 10100 plus line 10400, plus your share of the profits or losses. This income excludes pension income, interest, dividends from any source and any other investment income, rental income, capital gains, royalties, licence fees and support payments, and any deferred compensation and any other income that is not directly received in exchange for services rendered.		Last year	Prior to last year
	Salary	\$	\$
	Corporation's profit (or loss)	\$	\$
	Total	\$	\$
Fiscal year-end (yyyy/mm/dd):			
e) <input type="checkbox"/> Recognized agricultural producer: Earned income includes amortization expenses.	Annual income	Annual income (last year)	Annual income (prior to last year)
	\$	\$	\$

E - Eligibility (cont.)

E1 - Eligibility for SOLO disability coverages (cont.)

- 16- If you are self-employed, do you split your income for tax purposes? Yes No
If **yes**, what is the income splitting amount? \$ _____
- 17- Did your unearned income exceed \$30,000 in the past calendar year? Yes No
(Unearned income is income from sources other than your employment and is income that you would still receive even if you were disabled. Example: net profit from rental income, capital gains, non-professional dividends, interest.)
If **yes**, please indicate the total amount of your unearned income: \$ _____
- 18- Does your net worth (assets minus liabilities) exceed \$4,000,000? Yes No
If **yes**, complete **question 20** - Net worth.
- 19- Are you applying for the Benefit Payment Without Proof of Income? Yes No
If **yes**, financial proof is required to determine eligibility. Please refer to the Representative guide.

20- Net worth

Savings, liquid assets, stocks, bonds	\$
Business assets (excluding goodwill)	\$
Real estate property	\$
Other (specify)	\$
Total	\$

E2 - Eligibility for SOLO Healthcare

Is the proposed insured:	Insured 1	Insured 2
a) covered by the provincial health insurance plan?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b) covered by the provincial drug insurance plan? If no , specify the reason:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
c) a pregnant woman? If yes , specify the due date (yyyy/mm/dd): _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No




Desjardins Insurance refers to Desjardins Financial Security Life Assurance Company.

F - Insurability statement
F1 - Identification of proposed insureds

- If there are more than 2 proposed insureds, use another application form for them.

Insured 1		Insured 2	
First name		First name	
Last name at birth		Last name at birth	
Sex <input type="checkbox"/> Female <input type="checkbox"/> Male	Date of birth (yyyy/mm/dd)	Sex <input type="checkbox"/> Female <input type="checkbox"/> Male	Date of birth (yyyy/mm/dd)

F2 - Insurance in force

-  If this section is not completed, the application process can be delayed.

Individual life and critical illness coverages			Insured 1	Insured 2
Do you currently have individual life or critical illness insurance?			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<ul style="list-style-type: none"> Do not include the coverages applied for under this application, group insurance coverages and credit insurance from a bank or caisse. 				
If yes , please complete the table below for each individual insurance coverage held with Desjardins Insurance or another company.				
Insured 1	Amount \$	Name of company	Purpose of insurance	
			Personal	Business
LIFE			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
CI			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
Insured 2	Amount \$	Name of company	Purpose of insurance	
			Personal	Business
LIFE			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
CI			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>

SOLO disability coverages (SOLO Disability Income and SOLO Loan Insurance) Insured 1 or Insured 2

- Do you currently have disability insurance? Yes No

- Include any individual, group (including MÉDIC Construction) and credit insurance coverages you may have. Do not include the coverages applied for under this application.

If **yes**, please complete the table below for each disability insurance coverage held with Desjardins Insurance or another company.

If you are covered by the MÉDIC Construction insurance plan, please enter the plan letter here: _____

Disability insurance in force	Contract issue date (yyyy/mm/dd)	Monthly benefit	Waiting period	Benefit period	Taxable
Name of insurer					<input type="checkbox"/> Yes <input type="checkbox"/> No
Type of coverage <input type="checkbox"/> Credit insurance (bank/credit union) <input type="checkbox"/> Individual disability insurance <input type="checkbox"/> Credit insurance (e.g. SOLO Loan Insurance) <input type="checkbox"/> Overhead expense insurance <input type="checkbox"/> Group insurance					
Name of insurer					<input type="checkbox"/> Yes <input type="checkbox"/> No
Type of coverage <input type="checkbox"/> Credit insurance (bank/credit union) <input type="checkbox"/> Individual disability insurance <input type="checkbox"/> Credit insurance (e.g. SOLO Loan Insurance) <input type="checkbox"/> Overhead expense insurance <input type="checkbox"/> Group insurance					
Name of insurer					<input type="checkbox"/> Yes <input type="checkbox"/> No
Type of coverage <input type="checkbox"/> Credit insurance (bank/credit union) <input type="checkbox"/> Individual disability insurance <input type="checkbox"/> Credit insurance (e.g. SOLO Loan Insurance) <input type="checkbox"/> Overhead expense insurance <input type="checkbox"/> Group insurance					

F - Insurability statement (cont.)

F3 - Identification of attending physician

- Indicate the contact information of the doctor who has your medical records.

Insured 1			Insured 2 <input type="checkbox"/> Same as for Insured 1		
Doctor's first and last names			Doctor's first and last names		
Address (No., street, apt.)			Address (No., street, apt.)		
City	Province or territory	Postal code	City	Province or territory	Postal code
10-digit phone number	Date of your last visit (yyyy/mm/dd)		10-digit phone number	Date of your last visit (yyyy/mm/dd)	
Reason for your last visit and results			Reason for your last visit and results		

F4 - Examinations ordered by the representative

Instructions for the representative

- If you did not order any examination requirements, please do not complete this section. For those outside Quebec, please provide the requirements, and complete this section.
- When ordering requirements on a Prestige file, inform the Paramedical and Inspection provider that it is a Prestige case.

⚠ Paramedical firm

- Dynacare Insurance Solutions ExamOne Other:

⚠ Inspection firm

- Dynacare Insurance Solution (Keyfacts) Other:

	Paramedical exam	Blood profile	Resting ECG	Stress ECG	Urine test	MVR	Inspection report	Others
Insured 1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Insured 2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Authorization number for Insured 1 (mandatory): _____

Authorization number for Insured 2 (mandatory): _____

F5 - Mandatory questions for all proposed insureds

	Insured 1	Insured 2
1- Have you submitted this application to replace a life, disability or a critical illness insurance coverage issued by Desjardins Insurance or by another insurer? If yes , complete notice or prior notice of replacement. The coverage(s) under the following contract(s) will be cancelled if this application is approved.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Type of coverage	Insured 1			Insured 2		
	Insurance amount replaced	Name of company	Contract No. (if a Desjardins Insurance contract)	Insurance amount replaced	Name of company	Contract No. (if a Desjardins Insurance contract)
Life						
Disability						
Critical illness						

F - Insurability statement (cont.)

2- Have you submitted one or more life, disability or critical illness insurance applications that are currently under review with Desjardins Insurance or other companies? Yes No Yes No
 If **yes**, complete the table below.

Type of coverage	Insured 1			Insured 2		
	Amount under review (Include the amount applied for in this application)	Name of company	Total amount of insurance applied for after review (All insurance companies combined)	Amount under review (Include the amount applied for in this application)	Name of company	Total amount of insurance applied for after review (All insurance companies combined)
Life						
Disability						
Critical illness						

3- In the **past 10 years**, has Desjardins Insurance or another insurer denied your application for life, disability, critical illness or healthcare insurance? Yes No Yes No
 If **yes**, complete the table below.

	Coverage applied for				Year	Reason for denial
Insured 1	<input type="checkbox"/> Life	<input type="checkbox"/> Disability	<input type="checkbox"/> Critical illness	<input type="checkbox"/> Healthcare		
Insured 2	<input type="checkbox"/> Life	<input type="checkbox"/> Disability	<input type="checkbox"/> Critical illness	<input type="checkbox"/> Healthcare		

This question is for proposed insureds age 17 or older.

4- When did you last smoke or use products containing tobacco or nicotine?
 • **These products include:** cigarettes, e-cigarettes/vapes, cigarillos, large cigars (no filter), nicotine gum or patches, anti-smoking medication, tobacco mixed with marijuana/cannabis, or any other products containing tobacco or nicotine (for example, pipes, water pipes / hookahs, chewing tobacco, betel nuts)

Insured 1	<input type="checkbox"/> In the past 12 months	<input type="checkbox"/> Over 1 year ago	<input type="checkbox"/> Over 2 years ago	<input type="checkbox"/> Over 10 years ago	<input type="checkbox"/> Never
Insured 2	<input type="checkbox"/> In the past 12 months	<input type="checkbox"/> Over 1 year ago	<input type="checkbox"/> Over 2 years ago	<input type="checkbox"/> Over 10 years ago	<input type="checkbox"/> Never

If you have selected **In the past 12 months**, you must complete the table below.

	Products smoked or used	Complete only for: cigarettes, cigarillos and large cigars with no filter		
		Number of units	Frequency of use	
Insured 1			<input type="checkbox"/> Daily	<input type="checkbox"/> Monthly <input type="checkbox"/> Yearly
Insured 2			<input type="checkbox"/> Daily	<input type="checkbox"/> Monthly <input type="checkbox"/> Yearly

This question is for proposed insureds age 18 or older.

5- Have you declared bankruptcy within the **past 5 years**? Yes No Yes No
 If **yes**, complete the table below.

	Date of bankruptcy (yyyy/mm/dd)	Personal	Business	Date of discharge (yyyy/mm/dd)
Insured 1		<input type="checkbox"/>	<input type="checkbox"/>	
Insured 2		<input type="checkbox"/>	<input type="checkbox"/>	

If a paramedical exam or a tele-interview is required for a proposed insured, you do not have to complete **section F6** for the proposed insured.

F6 - Questions about your health and lifestyle

1. Height and weight

Insured 1						Insured 2											
Height			Weight			Weight 1 year ago			Height			Weight			Weight 1 year ago		
cm	ft	in	kg	lbs	kg	lbs	kg	lbs	cm	ft	in	kg	lbs	kg	lbs	kg	lbs
Cause of any weight loss of 4.5 kg (10 lbs) or more in the last year:									Cause of any weight loss of 4.5 kg (10 lbs) or more in the last year:								

F - Insurability statement (cont.)
2. Family history

		Insured 1	Insured 2
Has a member of your immediate biological family (father, mother, brother or sister) been diagnosed with any of the following conditions?			
<ul style="list-style-type: none"> • cancer or tumour • cardiomyopathy • multiple sclerosis (MS) • Parkinson's disease • heart disease • diabetes • Huntington's disease • Alzheimer's disease or dementia 	<ul style="list-style-type: none"> • stroke or transient ischemic attack (TIA) • polycystic kidney disease (PKD) • motor neurone disease (amyotrophic lateral sclerosis (ALS), Lou Gehrig's disease or other) • muscular dystrophy (Becker, Duchenne, Steinert, Thomsen disease or other) • other hereditary disease or health problem that has affected at least 2 members of your family (excluding high blood pressure or cholesterol) 	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

If **yes**, complete the table below.

Insured 1	Diagnosis (if cancer or a tumour, indicate type)	Age at diagnosis	Insured 2	Diagnosis (if cancer or a tumour, indicate type)	Age at diagnosis
Father			Father		
Mother			Mother		
Brother			Brother		
Sister			Sister		

The questions below are about your health and lifestyle. You do not have to provide information on the following:

- Adenoid removal – completed without complications
- Allergies
- Appendix removal – completed without complications
- Birth control
- Cosmetic surgery – completed without complications
- Hemorrhoids
- Hypothyroidism (underactive thyroid) in adults – if properly treated and not causing symptoms
- Menopause
- Tonsil removal – completed without complications
- Vaccines
- Vision problems that are corrected by glasses or contact lenses

We also request that you **do not provide us** with information about any genetic testing (DNA, RNA or chromosome) you've undergone or plan to undergo.

3. Medical history

		Insured 1	Insured 2
3.1- In the past 10 years , have you consulted a healthcare professional, received treatment, taken medication or undergone tests for any of the following reasons? If yes , complete the table below and provide relevant details in section F9 – Explanations .		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

	Insured			Insured	
	1	2		1	2
a) Tumour and cancer For example: lymphoma, leukemia, melanoma, or any other type of cancer	<input type="checkbox"/>	<input type="checkbox"/>	b) Heart and blood vessels For example: high blood pressure, high cholesterol, heart murmur, palpitations, chest pain, heart attack, Raynaud's disease, angina	<input type="checkbox"/>	<input type="checkbox"/>
c) Mental health, neurodivergence and developmental disabilities For example: anxiety, stress, adjustment disorder, depression, personality disorder, eating disorder, autism spectrum disorder, attention-deficit hyperactivity disorder (ADHD), Down syndrome, developmental delay	<input type="checkbox"/>	<input type="checkbox"/>	d) Diabetes and hormones (endocrine system) For example: thyroid issues, all types of diabetes including prediabetes, glucose intolerance	<input type="checkbox"/>	<input type="checkbox"/>
e) Muscles and bones For example: pain, fracture, sprain, torn ligament, tendinitis, dislocation, fibromyalgia, herniated disc, curvature of the spine, carpal tunnel, arthritis, sciatica	<input type="checkbox"/>	<input type="checkbox"/>	f) Genitals and urinary tract For example: urinary tract infection, kidney issues, sexually transmitted and blood-borne infections, gender affirmation, infertility, pregnancy complications, miscarriage, abnormal Pap test, ovary issues, endometriosis, fibroids, prostate issues	<input type="checkbox"/>	<input type="checkbox"/>
g) Breasts For example: pain, benign cysts or nodules, benign lumps and bumps, fibroadenoma, mastitis	<input type="checkbox"/>	<input type="checkbox"/>	h) Lungs and breathing For example: asthma, sleep apnea, pneumonia, chronic obstructive pulmonary disease (COPD), emphysema, chronic bronchitis, cystic fibrosis, collapsed lung, sarcoidosis	<input type="checkbox"/>	<input type="checkbox"/>

F - Insurability statement (cont.)

	Insured			Insured	
	1	2		1	2
i) Liver, gallbladder and pancreas For example: fatty liver disease, hepatitis, cirrhosis, pancreatitis, gallstones	<input type="checkbox"/>	<input type="checkbox"/>	j) Digestive system For example: pain, reflux, irritable bowel syndrome, Crohn's disease, ulcerative colitis, diverticulitis, hernia, polyps, celiac disease, ulcer	<input type="checkbox"/>	<input type="checkbox"/>
k) Brain and nervous system For example: headaches, stroke, cerebral palsy, Rett syndrome, muscular dystrophy, concussion, epilepsy, dizziness, multiple sclerosis, chronic fatigue syndrome, Alzheimer's disease	<input type="checkbox"/>	<input type="checkbox"/>	l) Eyes, ears, nose, mouth and throat For example: deafness, tinnitus, glaucoma, cataracts, crossed eyes, detached retina, vocal cord polyps	<input type="checkbox"/>	<input type="checkbox"/>
m) Blood For example: anemia, blood clot in leg (phlebitis), Factor V Leiden, iron overload, vitamin B12 deficiency, von Willebrand disease, low platelet count, varicose veins, hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	n) Skin For example: sebaceous cyst, eczema, mole that needs to be checked, psoriasis, fatty tumour, rash	<input type="checkbox"/>	<input type="checkbox"/>

	Insured 1	Insured 2
3.2- In the past 10 years : a) Have you been hospitalized? If yes , please provide relevant details in section F9 – Explanations .	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b) Have you undergone a test? For example: electrocardiogram, ultrasound, MRI, mammogram, colonoscopy, biopsy If yes , please provide relevant details in section F9 – Explanations .	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
c) Have you experienced symptoms for which you haven't yet consulted a doctor or other healthcare professional? If yes , please provide relevant details in section F9 – Explanations .	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3.3- Are you currently awaiting results or a follow-up concerning:		
• a test, biopsy or medical examination?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
• a consultation with a healthcare professional?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
• a treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
• a surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes , please provide relevant details in section F9 – Explanations		
3.4- In the past 10 years , were you disabled for more than 4 consecutive weeks? If yes , complete the table below.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

	Date of onset of disability (yyyy/mm/dd)	Cause of disability	Duration of disability
Insured 1			
Insured 2			

4. Alcohol or drug use

	Insured 1	Insured 2
4.1- Alcohol Do you generally consume more than 15 alcoholic beverages per week? If yes , indicate the quantity consumed below.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Weekly consumption	
Insured 1		
Insured 2		

F - Insurability statement (cont.)

		Insured 1	Insured 2
4.2- Cannabis and other drugs			
a) Have you used cannabis or cannabis products more than once a week in the past 12 months ? If yes , complete the table below.		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b) Have you used any drugs, opioids or non-prescribed drugs in the past 10 years ? If yes , complete the table below.		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

	Cannabis/cannabis products Check the applicable option	Quantity	Frequency	Period of use (yyyy/mm/dd)	
Insured 1	<input type="checkbox"/> Recreational use <input type="checkbox"/> Medical use <input type="checkbox"/> Recreational and medical use			From:	To:
Insured 2	<input type="checkbox"/> Recreational use <input type="checkbox"/> Medical use <input type="checkbox"/> Recreational and medical use			From:	To:
	Other drugs (for example: cocaine, hallucinogens, opiates, sedatives, inhalants, steroids, stimulants)	Quantity	Frequency	Period of use (yyyy/mm/dd)	
Insured 1				From:	To:
				From:	To:
Insured 2				From:	To:
				From:	To:

4.3- Treatment for alcohol or drug use			
a) Have you ever been treated for alcohol or drug use? (for example: inpatient or outpatient detoxification program, medication, inpatient or outpatient rehabilitation program) If yes , complete the table below.		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

	Substance used	Number of treatments undergone	Date of last treatment (yyyy/mm)	Date you last used this substance (yyyy/mm)
Insured 1	<input type="checkbox"/> Alcohol <input type="checkbox"/> Cannabis/cannabis products <input type="checkbox"/> Other drugs			
Insured 2	<input type="checkbox"/> Alcohol <input type="checkbox"/> Cannabis/cannabis products <input type="checkbox"/> Other drugs			

b) Have you ever participated in a support group? (for example: Alcoholics Anonymous) If yes , indicate the period: Insured 1: From: _____ To: _____ Insured 2: From: _____ To: _____ (yyyy/mm) (yyyy/mm) (yyyy/mm) (yyyy/mm)		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
c) Have you ever received a recommendation to reduce or stop your alcohol or drug use? If yes , complete the table below.		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

	Substance used	Motivating reason <input type="checkbox"/> For reducing <input type="checkbox"/> For stopping	Past use	Date use reduced or stopped (yyyy/mm)
Insured 1	<input type="checkbox"/> Alcohol <input type="checkbox"/> Cannabis/cannabis products <input type="checkbox"/> Other drugs			
Insured 2	<input type="checkbox"/> Alcohol <input type="checkbox"/> Cannabis/cannabis products <input type="checkbox"/> Other drugs			

d) Have you ever received a recommendation to receive treatment for your alcohol or drug use? If yes , complete the table below.		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Substance used	Type of treatment recommended	
Insured 1			
Insured 2			

F - Insurability statement (cont.)

5. Infractions

		Insured 1	Insured 2
5.1- In the past 5 years , have you committed:			
a) more than 2 traffic violations (excluding parking tickets)?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b) a traffic violation that led to your driver's licence being suspended or revoked (for example: impaired driving)?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes , complete the table below.			

	Date of offence (yyyy/mm)	Type of offence	Kilometres over the speed limit (for speeding offences)	Driver's licence reinstated (yyyy/mm)
Insured 1				
Insured 2				

5.2- In the past 5 years , have you been charged with or found guilty of an offence under the Criminal Code (including impaired driving)?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes , complete the table below.			

	Date of offence (yyyy/mm)	Type of offence	Sentence (for example: fine, probation, prison)	Prison sentence		Probation end date (yyyy/mm)
				Duration	Release date (yyyy/mm)	
Insured 1						
Insured 2						

6. Travel and dangerous activities

		Insured 1	Insured 2
6.1- Travel			
In the next 12 months , do you intend to travel, live or work outside Canada or the United States?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes , complete the table below.			

	Destination		Date of departure (yyyy/mm/dd)	Date of return (yyyy/mm/dd)	Purpose of trip (e. g., business, education, family or vacation)
	Country	City			
Insured 1					
Insured 2					

6.2- Dangerous activities			
a) In the past 12 months , have you participated in a dangerous activity?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b) In the next 12 months , do you intend to participate in any dangerous activity? For example: climbing, water, motor, combat, aerial, equestrian or winter sports		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes , complete the table below.			

	Insured 1	Insured 2
Activity name (If participating in more than 1 dangerous activity, provide the relevant details in section F10 – Other dangerous activities)		
Activity start date (yyyy/mm)		
In what way do you participate in this activity?	<input type="checkbox"/> Amateur <input type="checkbox"/> Professional	<input type="checkbox"/> Amateur <input type="checkbox"/> Professional

F - Insurability statement (cont.)

	Insured 1	Insured 2
Activity frequency		
Do you have any training, a certification or a licence to do this activity?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Country where the activity is or will be done		
If you have ever suffered serious injuries while doing this activity, indicate the date and nature of the injuries sustained, if applicable.		
Are you a member of a club or association?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

 If the activity is **diving or outdoor climbing/mountain climbing**, provide the following details:

Scuba diving

What is the maximum diving depth?		
Do you ever do ice, cavern or wreck diving? If yes , please specify: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you ever do this activity alone? If yes , please specify: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Outdoor climbing/mountain climbing

Type of climbing/mountain climbing done For example: ice, glacier, rock face		
What is the maximum altitude you reach (meter or feet)?		
Do you ever do this activity alone? If yes , please specify: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

7. Questions to be answered for SOLO Healthcare only

	Insured		Child			
	1	2	1	2	3	4
a) Have you used any medication for 20 consecutive days or more within the past 2 years ?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b) Have you taken or been advised to use a medication or treatment for a chronic or recurring medical condition or do you expect to use any medication or treatment within the next 3 months ? If yes , provide details below:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Note: Medications used for birth control or to treat minor ailments like cold or flu are not to be considered when answering this question.

Name of the proposed insured	Name of the drug, medication or treatment	Condition being treated	Strength and daily dosage of the drug or medication	Monthly cost	Length of time on this drug, medication or treatment

F7 - Additional questions - Critical illness coverage for any child under age 16

 • Complete this section **ONLY** if the proposed insured identified in **section A1** is a child **under age 16** and critical illness coverage is applied for.

General questions	Insured 1	Insured 2
If the proposed insured <u>does not have any siblings</u>, go to question 12.		
8- How many siblings does the proposed insured have?		
9- Do all of the proposed insured's siblings currently have critical illness insurance? If no , please explain why:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

F - Insurability statement (cont.)

	Insured 1	Insured 2
10- If all of the proposed insured's siblings currently have critical illness insurance, are they all insured for the same amount? If no , please explain why:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

11- Does the proposed insured have any siblings who have been diagnosed with autism spectrum disorder? If yes , complete the table below.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
---	--	--

Insured 1	Age at diagnosis	Insured 2	Age at diagnosis
Brother		Brother	
Brother		Brother	
Sister		Sister	
Sister		Sister	

12- Does the proposed insured's mother and/or father currently have critical illness insurance? If yes , indicate the insurance amount for each parent with critical illness insurance: If no , please explain why:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Mother	\$ _____ \$ _____
	Father	\$ _____ \$ _____

Medical history	Insured 1	Insured 2
13- If the proposed insured is currently under age 1 , was the term of their mother's pregnancy less than 36 weeks ? If yes , please explain why:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

F8 - Questionnaire regarding children to be insured

- To be completed **ONLY** if children are to be insured under the Children's Life Protection coverage or SOLO Healthcare.

Child 1				Child 2			
First name				First name			
Last name at birth				Last name at birth			
Sex <input type="checkbox"/> Female <input type="checkbox"/> Male		Date of birth (yyyy/mm/dd)		Sex <input type="checkbox"/> Female <input type="checkbox"/> Male		Date of birth (yyyy/mm/dd)	
Height cm ft in		Weight kg lbs		Weight 1 year ago kg lbs		Height cm ft in	
Cause of any weight loss of 4.5 kg (10 lbs) or more in the last year:				Cause of any weight loss of 4.5 kg (10 lbs) or more in the last year:			
Child 3				Child 4			
First name				First name			
Last name at birth				Last name at birth			
Sex <input type="checkbox"/> Female <input type="checkbox"/> Male		Date of birth (yyyy/mm/dd)		Sex <input type="checkbox"/> Female <input type="checkbox"/> Male		Date of birth (yyyy/mm/dd)	
Height cm ft in		Weight kg lbs		Weight 1 year ago kg lbs		Height cm ft in	
Cause of any weight loss of 4.5 kg (10 lbs) or more in the last year:				Cause of any weight loss of 4.5 kg (10 lbs) or more in the last year:			

F - Insurability statement (cont.)

Previous applications for insurance for the children

14- In the **past 10 years**, has Desjardins Insurance or another company declined an application for life, healthcare or critical illness insurance for the child to be insured?

Yes No

If **yes** for any of the children to be insured, complete the table below.

	Coverage applied for	Year	Reason for refusal
Child 1	<input type="checkbox"/> Life <input type="checkbox"/> Healthcare <input type="checkbox"/> Critical illness		
Child 2	<input type="checkbox"/> Life <input type="checkbox"/> Healthcare <input type="checkbox"/> Critical illness		
Child 3	<input type="checkbox"/> Life <input type="checkbox"/> Healthcare <input type="checkbox"/> Critical illness		
Child 4	<input type="checkbox"/> Life <input type="checkbox"/> Healthcare <input type="checkbox"/> Critical illness		

Medical questions for the children to be insured

The questions below are about the health of the children to be insured. You do not have to provide information on the following:

- Adenoid removal – completed without complications
- Allergies
- Appendix removal – completed without complications
- Birth control
- Cosmetic surgery – completed without complications
- Ear infections – fully healed without complications
- Sprains
- Tonsil removal – completed without complications
- Vaccines
- Vision problems that are corrected by glasses or contact lenses

We also request that you **do not provide us** with information about any genetic testing (DNA, RNA or chromosome) that the children to be insured have undergone or plan to undergo.

15- In the **past 10 years**, have any of the children to be insured ever consulted a healthcare professional, received treatment, taken medication or undergone tests for any of the following reasons?

Yes No

If **yes**, complete the table below for each applicable child and provide details in **section F9 – Explanations**.

	Child					Child			
	1	2	3	4		1	2	3	4
a) Tumour and cancer For example: lymphoma, leukemia, melanoma, or any other type of cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	b) Heart and blood vessels For example: heart murmur, irregular heartbeat, heart valve disorder or defect, congenital heart defect (atria or ventricles), cardiomyopathy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Mental health, neurodivergence and developmental disabilities For example: anxiety, stress, adjustment disorder, depression, personality disorder, eating disorder, autism spectrum disorder, attention-deficit hyperactivity disorder (ADHD), Down syndrome, developmental delay	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	d) Diabetes and hormones (endocrine system) For example: all types of diabetes including prediabetes, glucose intolerance, thyroid issues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Muscles and bones For example: pain, fracture, torn ligament, dislocation, curvature of the spine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	f) Genitals and urinary tract For example: urinary tract infection, kidney issues, sexually transmitted and blood-borne infections, gender affirmation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) Lungs and breathing For example: asthma, sleep apnea, pneumonia, chronic bronchitis, cystic fibrosis, collapsed lung	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	h) Liver, gallbladder and pancreas For example: hepatitis, jaundice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i) Digestive system For example: pain, reflux, irritable bowel syndrome, Crohn's disease, ulcerative colitis, hernia, pyloric stenosis, celiac disease, gastroenteritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	j) Brain and nervous system For example: headaches, concussion, epilepsy, Tourette syndrome, meningitis, muscular dystrophy, cerebral palsy, dysphasia, Rett syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k) Eyes, ears, nose, mouth and throat For example: deafness, cataract present at birth, cross eye (strabismus), laryngitis, mucous cyst, cleft palate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	l) Blood For example: sickle cell disease, anemia, Factor V Leiden, von Willebrand disease, low platelet count, hemophilia, thalassemia, agranulocytosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m) Skin For example: sebaceous cyst, eczema, mole that needs to be checked, psoriasis, fatty tumour, rash, benign hemangioma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					

G - Special instructions

- Provide additional details relevant to contract issue, premium payment or request for change.

H - Paying for the insurance

⚠ IMPORTANT: This section and the **09312E – Pre-Authorized Debit (PAD) Agreement** form, if applicable, **must** be completed for the proposed insured to benefit, **at no cost**, from the insurance offered in **section I – Provisional or conditional insurance**, while we are reviewing the application for coverages.

i If there are more than 2 contracts in this application, use another application to complete **section H – Paying for the insurance** for any additional contract(s).

H1 - Contract 1 payment

- Complete **About the contract** only if there are 2 contracts in the application.

About the contract

<input type="checkbox"/> New contract	Main coverages applied for and names of proposed insureds
<input type="checkbox"/> Changes to an in-force contract	Contract number

Saving the age

Does "saving the age" apply to the contract?

- Yes → Answer the questions below.
 No → Skip to the **Premium information** section.

1- If there has been a change in age since the illustration was saved **or** if the illustration issue date is before the date the illustration was saved, would you like to benefit from the premium shown in the illustration?

- Yes No

If you check **Yes**, you understand that the amount due will have to be paid **retroactively**:

- a) To the **day before the proposed insured's age changes**:
- For a new contract
- b) To the **day of the premium due date before the proposed insured's age changes**:
- For a contract issued to replace an in-force contract
 - For a contract issued after a privilege or option under an in-force contract is exercised
 - For an in-force contract to which a coverage is added

i For example, if the premium due date shown in the contract's Policy Schedule is the 22nd of each month and the insured person's age changed on February 13, 2026, the amount due will need to be paid retroactively to the 22nd day of the month before the age change, which is January 22, 2026.

2- Do you agree to have the amount due be paid **retroactively** to the day indicated above, as applicable?

- Yes No

If you check **Yes**:

- You agree to have the monthly premium indicated in the **Premium information** section and all other premiums due retroactively included in the first withdrawal.
- You understand that the proposed insureds will not be covered as of the day indicated above. Instead, they will be covered as of the effective date of the coverages applied for, as set out in your contract's General provisions.

If you check **No**, you understand that you must attach a new illustration to your insurance application.

Premium information

For a contract **without** the Additional Deposit Option (ADO)

- Annual premium: \$ _____ **OR** Monthly premium: \$ _____

Note: Universal life insurance premiums include the total cost of insurance, the savings and the provincial premium tax.

For a contract **with** the Additional Deposit Option (ADO)

⚠ Enter 0 on the Deposit line if you do not want to make a deposit at the same time as the premium payment.

- Annual** premium and deposit **OR** **Monthly** premium and deposit
- | | | | |
|----------------------|----------|-----------------------|----------|
| Premium: | \$ _____ | Premium: | \$ _____ |
| Deposit: | \$ _____ | Deposit: | \$ _____ |
| Total annual amount: | \$ _____ | Total monthly amount: | \$ _____ |

H - Paying for the insurance (cont.)

H2 - Contract 2 payment

- Complete **About the contract** only if there are 2 contracts in the application.

About the contract

<input type="checkbox"/> New contract	Main coverages applied for and names of proposed insureds
<input type="checkbox"/> Changes to an in-force contract	Contract number

Saving the age

Does "saving the age" apply to the contract?

- Yes → Answer the questions below.
- No → Skip to the **Premium information** section.

1- If there has been a change in age since the illustration was saved **or** if the illustration issue date is before the date the illustration was saved, would you like to benefit from the premium shown in the illustration?

- Yes No

If you check **Yes**, you understand that the amount due will have to be paid **retroactively**:

- a) To the **day before the proposed insured's age changes**:
 - For a new contract
- b) To the **day of the premium due date before the proposed insured's age changes**:
 - For a contract issued to replace an in-force contract
 - For a contract issued after a privilege or option under an in-force contract is exercised
 - For an in-force contract to which a coverage is added

i For example, if the premium due date shown in the contract's Policy Schedule is the 22nd of each month and the insured person's age changed on February 13, 2026, the amount due will need to be paid retroactively to the 22nd day of the month before the age change, which is January 22, 2026.

2- Do you agree to have the amount due be paid **retroactively** to the day indicated above, as applicable?

- Yes No

If you check **Yes**:

- You agree to have the monthly premium indicated in the **Premium information** section and all other premiums due retroactively included in the first withdrawal.
- You understand that the proposed insureds will not be covered as of the day indicated above. Instead, they will be covered as of the effective date of the coverages applied for, as set out in your contract's General provisions.

If you check **No**, you understand that you must attach a new illustration to your insurance application.

Premium information

For a contract without the Additional Deposit Option (ADO)

Annual premium: \$ _____ **OR** Monthly premium: \$ _____

Note: Universal life insurance premiums include the total cost of insurance, the savings and the provincial premium tax.

For a contract with the Additional Deposit Option (ADO)

⚠ Enter 0 on the Deposit line if you do not want to make a deposit at the same time as the premium payment.

<input type="checkbox"/> Annual premium and deposit	OR	<input type="checkbox"/> Monthly premium and deposit
Premium: \$ _____		Premium: \$ _____
Deposit: \$ _____		Deposit: \$ _____
Total annual amount: \$ _____		Total monthly amount: \$ _____

H - Paying for the insurance (cont.)

H3 - Other payment or reimbursement


- Complete this section to make a one-time payment or reimbursement for a new contract or when making changes to an in-force contract.

Contract 1	Payment method
<input type="checkbox"/> One-time deposit for the Additional Deposit Option coverage Amount: \$ _____	<input type="checkbox"/> Pre-authorized debit Complete the One-time payment section of the 09312E – Pre-Authorized Debit (PAD) Agreement form. OR <input type="checkbox"/> Cheque Please attach a cheque made out to Desjardins Insurance.
<input type="checkbox"/> Additional deposit made to the accumulation account (for universal life insurance contracts) Amount: \$ _____	<input type="checkbox"/> Pre-authorized debit Complete the One-time payment section of the 09312E – Pre-Authorized Debit (PAD) Agreement form. OR <input type="checkbox"/> Cheque Please attach a cheque made out to Desjardins Insurance.
<input type="checkbox"/> Repayment of a contract loan Amount: \$ _____	<input type="checkbox"/> Pre-authorized debit Complete the One-time payment section of the 09312E – Pre-Authorized Debit (PAD) Agreement form. OR <input type="checkbox"/> Cheque Please attach a cheque made out to Desjardins Insurance.
<input type="checkbox"/> Deposit into a Premium Deposit Account for premium payment purposes Amount: \$ _____ Provide instructions for withdrawing the recurring amount from the Premium Deposit Account :	<input type="checkbox"/> Pre-authorized debit Complete the One-time payment section of the 09312E – Pre-Authorized Debit (PAD) Agreement form. OR <input type="checkbox"/> Cheque Please attach a cheque made out to Desjardins Insurance.
 Some conditions may apply to using the account.	
Contract 2	Payment method
<input type="checkbox"/> One-time deposit for the Additional Deposit Option coverage Amount: \$ _____	<input type="checkbox"/> Pre-authorized debit Complete the One-time payment section of the 09312E – Pre-Authorized Debit (PAD) Agreement form. OR <input type="checkbox"/> Cheque Please attach a cheque made out to Desjardins Insurance.
<input type="checkbox"/> Additional deposit made to the accumulation account (for universal life insurance contracts) Amount: \$ _____	<input type="checkbox"/> Pre-authorized debit Complete the One-time payment section of the 09312E – Pre-Authorized Debit (PAD) Agreement form. OR <input type="checkbox"/> Cheque Please attach a cheque made out to Desjardins Insurance.
<input type="checkbox"/> Repayment of a contract loan Amount: \$ _____	<input type="checkbox"/> Pre-authorized debit Complete the One-time payment section of the 09312E – Pre-Authorized Debit (PAD) Agreement form. OR <input type="checkbox"/> Cheque Please attach a cheque made out to Desjardins Insurance.
<input type="checkbox"/> Deposit into a Premium Deposit Account for premium payment purposes Amount: \$ _____ Provide instructions for withdrawing the recurring amount from the Premium Deposit Account :	<input type="checkbox"/> Pre-authorized debit Complete the One-time payment section of the 09312E – Pre-Authorized Debit (PAD) Agreement form. OR <input type="checkbox"/> Cheque Please attach a cheque made out to Desjardins Insurance.
 Some conditions may apply to using the account.	



Desjardins Insurance refers to Desjardins Financial Security Life Assurance Company.

I - Provisional or conditional insurance


 **For the proposed insured to be entitled to provisional or conditional insurance, section H – Paying for the insurance must be completed.**

No provisional or conditional insurance will apply to:

- a coverage that is issued when an option provided for in a contract is exercised (e.g., conversion, exchange, insurability, guaranteed insurability);
- a coverage to which changes are made, when evidence of insurability is required (e.g., smoker to non-smoker rate, exclusion review, extra premium review);
- a SOLO Healthcare coverage.

I1 - PROVISIONAL LIFE INSURANCE AGREEMENT

If we need to further review the coverages requested, each person for whom one or more coverages that pay a death benefit have been requested will be covered under the Provisional life insurance at no cost.

 The Accident and the Accidental Death, Dismemberment or Loss of Use additional coverages are not included in the Provisional life insurance. As a result, no amount will be payable under the Provisional life insurance for those coverages.

Eligibility

Only 1 condition needs to be met

By the date the application is signed, the premium payment information must be provided in **section H - Paying for the insurance**.

Why it is important to provide accurate information

If the information about the insured person that is provided when applying for the insurance is inaccurate or incomplete, we may cancel the Provisional life insurance for that person and/or deny a claim.

Start of coverage

The Provisional life insurance starts when the application is signed.

Amount payable following a claim

Claims must be made in writing using the required form. We reserve the right to request additional documents and information to review a claim.

What is the amount payable?

We pay the amount of each coverage that pays a benefit if the insured person dies.

Who do we pay the amount payable to?

We pay the amount payable to the designated beneficiary. If no beneficiary has been designated, we pay the amount payable based on applicable legislation.

Limitations and exclusions

1- Limitation applicable to the amount payable

When the insured person has one or more Provisional life insurance agreements in force with us, the total amount payable for all the coverages that pay a death benefit is limited to:

- a) **\$1,000,000** if the insured person is 75 or under when they die;
- b) **\$50,000** if the insured person is over 75 when they die.

2- Exclusions

- a) No amount will be payable if, in **the 5 years prior to** when the application is signed, the insured person:
 - received treatment or consulted a physician or other healthcare professional for signs or symptoms related to the condition that led to their death;
 - underwent tests or exams that showed signs or symptoms related to the condition that led to their death.
- b) No amount will be payable if the insured person is under the age of 15 days when they die.
- c) No amount will be payable if the insured person's death results from suicide.
- d) No amount will be payable if the insured person's death results from a health condition that existed when the application was signed and for which medical assistance in dying was provided.

End of coverage

The insured person's Provisional life insurance ends on the **earliest** of the following dates:

- 1- Automatically, on the effective date of the coverages that pay a death benefit.
- 2- The date the insured person's application for all the coverages that pay a death benefit is denied.
- 3- The date the application is closed.
- 4- Automatically, on the 91st day after the date the application is signed.

I - Provisional or conditional insurance (cont.)

12 - PROVISIONAL CRITICAL ILLNESS INSURANCE AGREEMENT

If we need to further review the coverages requested, each person for whom one or more Health Priorities or Critical Illness Advance coverages have been requested will be covered under the Provisional critical illness insurance at no cost.

Part 1 – Coverage description

This part is rounded out with [Part 2 – Definition of covered conditions](#) of the Provisional critical illness insurance agreement and is an integral part of it. Your representative will describe and provide you with a copy of this document (available on [web](#)).

Eligibility

Only 1 condition needs to be met

By the date the application is signed, the premium payment information must be provided in **section H - Paying for the insurance**.

Why it is important to provide accurate information

If the information about the insured person that is provided when applying for the insurance is inaccurate or incomplete, we may cancel the Provisional critical illness insurance for that person and/or deny a claim.

Start of coverage

The Provisional critical illness insurance starts when the application is signed.

Amount payable following a claim

Claims must be made in writing using the required form. We reserve the right to request additional documents and information to review a claim.

What is the amount payable?

If the insured person suffers from one of the conditions listed below, we pay the amount for each Health Priorities and Critical Illness Advance coverage requested.

Who do we pay the amount payable to?

We pay the amount payable to the designated beneficiary. If no beneficiary has been designated, we pay the amount payable based on applicable legislation.

Covered conditions

We may pay the amount payable for the following conditions:

Cardiovascular

- Aortic surgery
- Coronary artery bypass surgery
- Heart attack
- Heart valve replacement or repair
- Stroke (cerebrovascular accident)

Neurological

- Bacterial meningitis

Vital organs

- Kidney failure
- Major organ failure on waiting list
- Major organ transplant

Accidents and functional loss

- Acquired brain injury
- Blindness
- Coma
- Deafness
- Loss of limbs
- Loss of speech
- Paralysis
- Severe burns

Other

- Aplastic anemia
- Occupational HIV infection
- Permanent loss of independent existence

⚠ Just because the insured person suffers from a covered condition, it does not mean we will pay the amount payable. For us to be able to pay the amount payable, the condition must meet, in every respect, all the conditions set out in the definition of that condition in **Part 2 – Definition of covered conditions**.

I - Provisional or conditional insurance (cont.)

12 - PROVISIONAL CRITICAL ILLNESS INSURANCE AGREEMENT (cont.)

Limitations and exclusions

1- Limitation applicable to the amount payable

When the insured person has one or more Provisional critical illness insurance agreements in force with us, the total amount payable for all the Health Priorities and Critical Illness Advance coverages requested is limited to **\$500,000**.

2- General exclusions

a) No amount will be payable for a covered condition:*

1. If, **in the 5 years prior to** when the application is signed, the insured person:
 - suffered from this condition;
 - received treatment or consulted a physician or other healthcare professional for signs or symptoms related to this condition;
 - underwent tests or exams that showed signs or symptoms related to this condition.
2. If, **in the 90 days prior to** when the application is signed, the insured person had signs or symptoms for which they did not consult a physician or other healthcare professional and that are related to this condition.

* Nor for any other covered condition that may result from this condition.

b) No amount will be payable if the covered condition results directly or indirectly from:

1. self-inflicted injuries or a suicide attempt;
2. the insured person's participation in any criminal act or related act;
3. war (whether war is declared or undeclared), riot or revolution, whether or not the insured person took part;
4. the insured person driving a motor vehicle while under the influence of drugs or with a blood alcohol level equal to or greater than 80 mg of alcohol per 100 ml of blood;
5. the illegal or illicit use of any drug;
6. the voluntary absorption or use of any toxic substance or any type of gas;
7. the voluntary consumption of prescription drugs that exceeds the dosage recommended by a healthcare professional or of drugs obtained without a prescription that exceeds the manufacturer's recommended dosage.

c) No amount will be payable if the covered condition is diagnosed after the insured person's death.


3- Additional exclusion for newborns

This exclusion may apply if the insured person is a newborn who is under the age of 15 days when the application is signed.

No amount will be payable for a covered condition* if, before reaching the age of 15 days, the insured person:

- suffered from this condition;
- had signs or symptoms related to this condition;
- received treatment for signs or symptoms related to this condition;
- underwent tests or exams that showed signs or symptoms related to this condition.

* Nor for any other covered condition that may result from this condition.

 **The limitations and exclusions set out in the definition of the covered conditions are in addition to the above-mentioned exclusions.**

End of coverage

The insured person's Provisional critical illness insurance ends on the **earliest** of the following dates:

- 1- The date we pay the amount payable under the insured person's Provisional critical illness insurance.
- 2- Automatically, on the effective date of the Health Priorities or Critical Illness Advance coverages requested.
- 3- The date the insured person's application for all the Health Priorities and Critical Illness Advance coverages requested is denied.
- 4- The date the application is closed.
- 5- Automatically, on the 91st day after the date the application is signed.

I - Provisional or conditional insurance (cont.)

13 - CONDITIONAL DISABILITY INSURANCE AGREEMENT

The [SOLO Disability Income](#) and/or [SOLO Loan Insurance](#) sample contracts round out the Conditional disability insurance agreement. Your representative will describe and provide you with a copy of the sample contract(s) that are relevant to your application. The sample contracts are available on [web](#).

i The terms in italics in this text have the same definitions as the ones in the text about coverages included in the SOLO contract to be issued, if applicable.

Purpose of Conditional disability insurance

The Conditional disability insurance makes it possible to move up the effective date of coverages that is defined in the General provisions of the SOLO contract to be issued, if the insured person becomes *disabled* and all the conditions in the **Applicable conditions** section are met.

The effective date of the coverages to be issued may be moved up:

- to the date on which the application is signed, if the *disability* is the result of an **accident**;
- to the date on which the insured person answered all the insurability questions and underwent all the required examinations and/or tests, if the *disability* is the result of an **illness**.

The insured person may then be covered by the coverages of the contract to be issued starting on one of these dates, depending on the cause of their *disability*.

Applicable conditions

- 1- By the date the application is signed, the premium payment information must be provided in **section H - Paying for the insurance**.
- 2- We must approve the coverages requested in this application with or without changes (see the **Approval of coverages requested with or without changes** section below).
- 3- The **accident** that causes the insured person's *disability* must occur:
 - a) after the application is signed; and
 - b) before the earliest of the following dates:
 - the effective date of the coverages defined in the General provisions of the contract to be issued; and
 - the 91st day after the date the application is signed.

OR

The **illness** that causes the insured person's *disability* must occur:

- a) after they have answered all the insurability questions and undergone all the required examinations and/or tests; and
 - b) before the earliest of the following dates:
 - the effective date of the coverages defined in the General provisions of the contract to be issued; and
 - the 91st day after the date the application is signed.
- 4- The *monthly benefit* must be payable according to the contract to be issued (see the **About the contract to be issued** section below).

Why it is important to provide accurate information

If the information about the insured person that is provided when applying for the insurance is inaccurate or incomplete, we may cancel the contract to be issued for that person and/or deny a claim. The Conditional disability insurance would therefore not be applicable.

Approval of coverages requested with or without changes

We decide whether to approve the coverages requested with or without changes, or deny them, using Desjardins Insurance's underwriting rules and taking into account all the information collected about the proposed insured for the application.

When the Conditional disability insurance is applicable, our decision will not take into account:


- any *accident* that may occur after the application is signed; and
 - any *illness* that may occur after the insured person has answered all the insurability questions and undergone all the required examinations and/or tests.
- 1- **When we approve the coverages requested without changes**, this means that we will cover the insured person in the event of a *disability* as set out in the contract to be issued.

If the insured person becomes *disabled*, the effective date of the coverages in the contract to be issued may be moved up, if all the conditions in the **Applicable conditions** section are met.

I - Provisional or conditional insurance (cont.)

13 - CONDITIONAL DISABILITY INSURANCE AGREEMENT (cont.)

- 2- **When we approve the coverages requested with changes**, this means that we will cover the insured person in the event of a *disability* as set out in the contract to be issued with **additional** exclusions and/or limitations (e.g., adding an exclusion, increasing the waiting period, decreasing the selected monthly benefit, etc.).

 For example, if the contract is issued with 2 additional exclusions, one for a specific health condition and one for participation in hazardous sports, this means that no *monthly benefit* would be payable if the insured person becomes *disabled* as a result of this health condition or sport while or after the application is reviewed.

If the insured person becomes *disabled*, the effective date of the coverages in the contract to be issued may be moved up, if all the conditions in the **Applicable conditions** section are met.


- 3- **When we deny the coverages requested**, this means we will not issue a contract for the insured person and they will not be covered in the event of a *disability*.

The Conditional disability insurance would therefore not be applicable.

About the contract to be issued

While waiting to receive their contract, the policyowner should refer to the **SOLO Disability Income sample contract** and/or **SOLO Loan Insurance sample contract**, as applicable, to understand:

- the scope of the Conditional disability insurance; and
- the conditions, limitations and exclusions applicable to the coverages requested.

 The sample contract **does not replace** the contract to be issued because it is not personalized based on the coverages requested in this application. It includes the text of the General provisions and all the coverages that can be included in a SOLO contract.



Desjardins Insurance refers to Desjardins Financial Security Life Assurance Company.

J - Notice applicable to MIB, LLC – Give to proposed insured 1

Who is MIB, LLC?

MIB, LLC (“MIB”) operates an information exchange on behalf of insurance companies that are members of MIB Group Inc. and with operations in Canada and the United States. The organization operates a database of consumer reports, which are comprised of information contributed by member insurance companies.

What information do we exchange, and why?

Like almost every Canadian insurer that offers life and health insurance, Desjardins Insurance is a member of MIB and can exchange information about you with the organization.

MIB makes it possible to verify the accuracy and completeness of the information provided by clients of member insurance companies.

We only exchange information on factors that could have a serious effect on your health or life expectancy. These factors include:

- Serious medical conditions
- A dangerous hobby
- A poor driving record
- Alcohol or drug use
- A criminal record

The information we contribute to MIB then becomes available to other MIB member insurance companies. MIB generally keeps this information on file for 7 years.

When do we exchange this information?

When we receive:

- An insurance application about you
- A claim

Also, if another member company receives an insurance application about you within 2 years following our receipt of this insurance application, we may share information with MIB for the benefit of that member company.

Your personal information is protected

MIB is bound by the same personal information confidentiality requirements as other Canadian insurers and must respect all federal and provincial privacy laws.

Since MIB is based in the United States, your information could be transferred outside Canada. Note that MIB must also comply with US privacy laws.

To learn more, review MIB’s Consumer Privacy Policy at www.mib.com/privacy_policy.html.

You have the right to access your personal information and correct any inaccuracies, if necessary

To do so, contact MIB directly in one of the following ways:

- By email canadadisclosure@mib.com
- By phone 1-866-692-6901
- By mail MIB, LLC
50 Braintree Hill Park, Suite 400
Braintree MA 02184-8734 USA
- Website www.mib.com



Desjardins Insurance refers to Desjardins Financial Security Life Assurance Company.

J - Notice applicable to MIB, LLC – Give to proposed insured 2

Who is MIB, LLC?

MIB, LLC (“MIB”) operates an information exchange on behalf of insurance companies that are members of MIB Group Inc. and with operations in Canada and the United States. The organization operates a database of consumer reports, which are comprised of information contributed by member insurance companies.

What information do we exchange, and why?

Like almost every Canadian insurer that offers life and health insurance, Desjardins Insurance is a member of MIB and can exchange information about you with the organization.

MIB makes it possible to verify the accuracy and completeness of the information provided by clients of member insurance companies.

We only exchange information on factors that could have a serious effect on your health or life expectancy. These factors include:

- Serious medical conditions
- A dangerous hobby
- A poor driving record
- Alcohol or drug use
- A criminal record

The information we contribute to MIB then becomes available to other MIB member insurance companies. MIB generally keeps this information on file for 7 years.

When do we exchange this information?

When we receive:

- An insurance application about you
- A claim

Also, if another member company receives an insurance application about you within 2 years following our receipt of this insurance application, we may share information with MIB for the benefit of that member company.

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You have the right to access your personal information and correct any inaccuracies, if necessary


To do so, contact MIB directly in one of the following ways:

- By email canadadisclosure@mib.com
- By phone 1-866-692-6901
- By mail MIB, LLC
50 Braintree Hill Park, Suite 400
Braintree MA 02184-8734 USA
- Website www.mib.com



Desjardins Insurance refers to Desjardins Financial Security Life Assurance Company.

K - Consent related to the management of your personal information by Desjardins Group

-  This consent applies to:
- each **policyowner (Individual)**
 - each **proposed insured**

1. Management of your personal information

To serve you on a daily basis and meet our legal obligations, we need to collect, use and disclose information about you. For more details, see Desjardins Group's Privacy Policy at www.desjardins.com/privacy-policy.

You may be asked for specific consent to ensure that Desjardins Insurance can deliver or continue to deliver service. This will be done in compliance with Desjardins Group's Privacy Policy.

Desjardins Insurance handles all your personal information confidentially. Your information will be accessed only by employees who require it to complete their tasks.

2. Your rights

You can:

- See the personal information Desjardins Group has about you
- Correct any information that's incomplete, ambiguous or not relevant

To find out how, see Desjardins Group's Privacy Policy.

3. Collection or transfer of your personal information outside of Canada

Desjardins Insurance uses service providers located outside of Canada to perform certain specific activities in its normal course of business. As such, personal information may be collected in and/or transferred to another country and be subject to the laws of that country.

For information about our policies and practices regarding the collection and transfer of personal information outside of Canada, see Desjardins Group's Privacy Policy. You can also obtain this information, or ask any questions you might have, by calling us at 1-800-278-0669.

By signing this section, you:

- Acknowledge that you've looked at Desjardins Group's Privacy Policy, which is available at www.desjardins.com/privacy-policy
- Authorize Desjardins Group to collect, use and disclose your personal information based on the conditions outlined in the policy and applicable regulations
- Acknowledge and accept that this consent takes precedence over any other consent you've previously signed
- Acknowledge that this consent remains valid for as long as you have a business relationship with a Desjardins Group component

 **Please sign the next page**

K - Consent related to the management of your personal information by Desjardins Group (cont.)
Policyowners

X _____
 Signature of policyowner (Individual)

 Signed at (city, province or territory) Date (yyyy/mm/dd)

Check the option that applies:

- Policyowner 1** identified in **section A1** – Individual
- Policyowner identified in **section A2** – Individual
- Authorized signatory identified in **section A3** (policyowner of major age who has been declared legally incapable)

X _____
 Signature of second policyowner (Individual)

 Signed at (city, province or territory) Date (yyyy/mm/dd)

Check the option that applies:

- Policyowner 2** identified in **section A1** – Individual
- Policyowner identified in **section A2** – Individual
- Authorized signatory identified in **section A3** (policyowner of major age who has been declared legally incapable)

Proposed insureds age 14 or older (Quebec) or 16 or older (provinces or territories other than Quebec)

- If the proposed insured is of major age and has been declared legally incapable, the authorized signatory identified in **section A3** must sign on their behalf.

X _____
 Signature of proposed insured 1

 Signed at (city, province or territory) Date (yyyy/mm/dd)

X _____
 Signature of proposed insured 2

 Signed at (city, province or territory) Date (yyyy/mm/dd)

SOLO Healthcare and Children's Life Protection coverages: children age 14 or older (Quebec) or 16 or older (provinces or territories other than Quebec)

- If the proposed insured is of major age and has been declared legally incapable, the authorized signatory identified in **section A3** must sign on their behalf.

X _____
 Signature of Child 1

 Signed at (city, province or territory) Date (yyyy/mm/dd)

X _____
 Signature of Child 2

 Signed at (city, province or territory) Date (yyyy/mm/dd)

X _____
 Signature of Child 3

 Signed at (city, province or territory) Date (yyyy/mm/dd)

X _____
 Signature of Child 4

 Signed at (city, province or territory) Date (yyyy/mm/dd)

If the proposed insured is **under age 14** (Quebec) or **under age 16** (provinces or territories other than Quebec), the signature of a parent, guardian or legal representative is required.

- Person signing: Parent (father or mother) Guardian (Quebec) Legal representative (provinces or territories other than Quebec)
- Signing for: Proposed insured 1 Proposed insured 2
- Child 1 Child 2 Child 3 Child 4 (SOLO Healthcare and Children's Life Protection coverages)

 First and last names of the person signing for the proposed insured (please print)

 Signed at (city, province or territory) Date (yyyy/mm/dd)

X _____
 Signature


- Person signing: Parent (father or mother) Guardian (Quebec) Legal representative (provinces or territories other than Quebec)
- Signing for: Proposed insured 1 Proposed insured 2
- Child 1 Child 2 Child 3 Child 4 (SOLO Healthcare and Children's Life Protection coverages)

 First and last names of the person signing for the proposed insured (please print)

 Signed at (city, province or territory) Date (yyyy/mm/dd)

X _____
 Signature

L - Consent related to the management of your personal information by Desjardins Insurance

 This consent applies to each **proposed insured**.

1. Why Desjardins Insurance needs your consent

Your consent allows us to collect, use and disclose the personal information we require to:

1. Analyze your insurance applications
2. Manage your file while you're covered under the insurance
3. Process claims

Your consent also allows us to do the following, as required:

- Look at information in any old insurance file you may have with Desjardins Insurance.
- Ask a personal information broker to provide us with an investigation report about you, if necessary.
- Send a summary of your personal information, including health-related information, to MIB, LLC (see text box below), after analyzing an insurance application you've submitted.

MIB, LLC is an organization that operates a database allowing insurance companies in Canada and the United States to collect and disclose information about their clients.

- Send your doctor any medical information that we obtained about you when analyzing your insurance applications or claims, so they can share it with you.
- Provide insurers and reinsurers with any relevant information (medical test results, etc.), so they can assess an insurance application you've submitted.

By giving your consent to us, you also authorize our reinsurers to collect, use and disclose your personal information the same way we would. Our reinsurers are companies that insure us, Desjardins Insurance.

2. Who your personal information will be collected from or disclosed to

You give your consent for the collection and disclosure of the necessary information with you, but also with other people and organizations. These people and organizations include:

- MIB, LLC
- Healthcare professionals or establishments (doctors, hospitals, clinics, etc.)
- Healthcare providers
- Paramedical firms
- Public or parapublic organizations
- Insurance companies other than Desjardins Insurance
- Reinsurers
- Your employer or a former employer
- The policyowner, if you aren't that person
- Other Desjardins components, if they're involved in the insurance
- A personal information broker or an investigation firm

3. If the application concerns your children

You authorize us to collect, use and disclose the necessary information about them, if they're under age 14 (Quebec) or under age 16 (all other provinces and territories).

By signing the next page, you authorize Desjardins Insurance and its reinsurers to collect, use and disclose your personal information based on the conditions outlined in this section, the applicable regulations and Desjardins Group's Privacy Policy. You can consult the policy at www.desjardins.com/privacy-policy.

 **Please sign the next page**

L - Consent related to the management of your personal information by Desjardins Insurance (cont.)

Proposed insureds age **14 or older** (Quebec) or **16 or older** (provinces or territories other than Quebec)

- If the proposed insured is of major age and has been declared legally incapable, the authorized signatory identified in **section A3** must sign on their behalf.

X _____
Signature of proposed insured 1

X _____
Signature of proposed insured 2

Signed at (city, province or territory)

Date (yyyy/mm/dd)

Signed at (city, province or territory)

Date (yyyy/mm/dd)

SOLO Healthcare and Children's Life Protection coverages: children age **14 or older** (Quebec) or **16 or older** (provinces or territories other than Quebec)

- If the proposed insured is of major age and has been declared legally incapable, the authorized signatory identified in **section A3** must sign on their behalf.

X _____
Signature of Child 1

X _____
Signature of Child 2

Signed at (city, province or territory)

Date (yyyy/mm/dd)

Signed at (city, province or territory)

Date (yyyy/mm/dd)

X _____
Signature of Child 3

X _____
Signature of Child 4

Signed at (city, province or territory)

Date (yyyy/mm/dd)

Signed at (city, province or territory)

Date (yyyy/mm/dd)

If the proposed insured is **under age 14** (Quebec) or **under age 16** (provinces or territories other than Quebec), the signature of a parent, guardian or legal representative is required.

Person signing: Parent (father or mother) Guardian (Quebec) Legal representative (provinces or territories other than Quebec)

Signing for: Proposed insured 1 Proposed insured 2
 Child 1 Child 2 Child 3 Child 4 (SOLO Healthcare and Children's Life Protection coverages)

First and last names of the person signing for the proposed insured (please print)

X _____
Signature

Signed at (city, province or territory)

Date (yyyy/mm/dd)

Person signing: Parent (father or mother) Guardian (Quebec) Legal representative (provinces or territories other than Quebec)

Signing for: Proposed insured 1 Proposed insured 2
 Child 1 Child 2 Child 3 Child 4 (SOLO Healthcare and Children's Life Protection coverages)

First and last names of the person signing for the proposed insured (please print)

X _____
Signature

Signed at (city, province or territory)

Date (yyyy/mm/dd)

N - Statements and authorizations

- 1- The policyowner and the proposed insured declare that all answers and statements provided in this application, or in any other questionnaire or form relating to it, are true and complete. They understand that the contract will be issued based on these answers and statements.
They also understand that the contract will be issued based on all additional information collected by Desjardins Insurance concerning the insurability of the proposed insured in order to review the application (questionnaires, examinations, tests, phone interviews, etc.).
- 2- The policyowner and the proposed insured agree to notify Desjardins Insurance of any change that may affect the insurability of the proposed insured between the date the application is signed and the effective date of the coverages applied for, as defined in the General provisions of the contract to be issued. Such a change may include:
 - A change in health status
 - An illness, disease, disorder, injury, operation or treatment
 - A consultation, examination or treatment by any healthcare professional
 - A recommendation for a medical appointment or consultation with a healthcare professional that has not yet taken place
 - A medical test or recommendation to have a medical test of any kind that has not yet taken place
 - An accident
 - A change in occupation, tasks or responsibilities
 - A change in lifestyle habits:
 - Use of tobacco, nicotine products, alcohol, cannabis, etc.
 - Participation in hazardous sports
 - Travel or stay outside Canada or the United States
 - A Highway Safety Code offence (or any offence to other similar laws)
 - A Criminal Code offence
 - Etc.
- 3- The proposed insured agrees to have insurance issued on them.
- 4- The proposed insured agrees to have their personal information on this application, or on any other questionnaire or form relating to it, disclosed to the policyowner.
- 5- The policyowner acknowledges that:
 - a) they were given an accurate description of the product and a detailed explanation of the nature of the coverages applied for;
 - b) the exclusions applicable to the coverages were clearly explained;
 - c) they received or were presented the illustration outlining the values and/or features of the coverages applied for;
 - d) the information provided on their "Declaration of tax residence" is correct and complete (if applicable). They agree to give Desjardins Insurance a new declaration within 30 days in the event of a change in circumstances;
 - e) they will provide Desjardins Insurance any business or trust number missing from **section A2 – Identification of a policyowner who is not a proposed insured** within 90 days;
 - f) they agree to provide Desjardins Insurance, within 90 days, if applicable, a copy of any valid cannabis licence issued by Health Canada and, if required by the nature of their business activities, by the Canada Revenue Agency;
 - g) the representative has disclosed either verbally or in writing the names of all life and health insurance companies on whose behalf they sell products, that they receive commissions or a salary for the sale of their life and health insurance products and that they may qualify for additional compensation, such as bonuses, or non-monetary benefits, such as participation in conferences or other recognition activities.
- 6- If "saving the age" applies to **section H – Paying for the insurance**:
 - a) The policyowner agrees to have the monthly premium indicated in the **Premium information** subsection and all other premiums due retroactively included in the first withdrawal.
 - b) The policyowner understands that the proposed insureds will not be covered as of the day indicated in the **Saving the age** subsection. Instead, they will be covered as of the effective date of the coverages applied for, as set out in the contract's General provisions.
- 7- **If this application is signed in Quebec:** unless the contract is issued as the result of a modification, the policyowner understands that they will receive a French version of all the documents forming their contract (if the contract is issued) and asks that these documents and any future documents regarding the insurance applied for be provided to them in English.
Si cette proposition est signée au Québec : sauf si le contrat est établi à la suite d'une modification, le preneur comprend qu'il recevra une version française de tous les documents qui constituent son contrat (si ce dernier est établi) et demande que ces documents et tout document futur relatif à l'assurance demandée lui soient fournis en anglais.
- 8- The policyowner understands that if the "When the contract is delivered" option has been selected in **section H – Paying for the insurance**, the benefits related to disclosing payment information will not apply.
- 9- The policyowner and the proposed insured acknowledge that any misrepresentation, including the misrepresentation of the use of tobacco or nicotine products, may void the contract.
- 10- The proposed insured acknowledges that they have read **section J - Notice applicable to MIB, LLC**.
- 11- The policyowner and the proposed insured have read this section before signing it.
- 12- The policyowner acknowledges that the representative described the Provisional life insurance agreement, if applicable, and that they accept all the applicable conditions, limitations and exclusions.
- 13- The policyowner acknowledges that the representative described the Provisional critical illness insurance agreement, if applicable, and that they accept the applicable conditions, limitations and exclusions. They also acknowledge that the representative presented and described both Part 1 – Coverage description set out in **section I2 – Provisional critical illness insurance agreement** and Part 2 – Definition of covered conditions of the Provisional critical illness insurance agreement.

N - Statements and authorizations (cont.)

- 14- The policyowner acknowledges that the representative explained the nature of the Conditional disability insurance agreement, if applicable. They also acknowledge that the representative presented and described the SOLO Disability Income or SOLO Loan Insurance sample contract, as the case may be.
- 15- **For coverages that pay an amount in case of death or critical illness:** The policyowner understands that the proposed insured will be covered under the coverages requested or under provisional insurance, if applicable, as of when the application is signed, provided that the following conditions are met:
- the "When the contract is delivered" option must not have been selected in **section H – Paying for the insurance**;
 - the premium payment information must be provided in **section H – Paying for the insurance**; and
 - if the payment method chosen in this section is pre-authorized debits, the **09312E – Pre-Authorized Debit (PAD) Agreement** form must be duly completed and attached to this application.
- 16- **For coverages that pay an amount in case of disability:** The policyowner understands that the proposed insured may benefit from the advantages of the Conditional disability insurance, if applicable, provided that the following conditions are met:
- the "When the contract is delivered" option must not have been selected in **section H – Paying for the insurance**;
 - the premium payment information must be provided in **section H – Paying for the insurance**; and
 - if the payment method chosen in this section is pre-authorized debits, the **09312E – Pre-Authorized Debit (PAD) Agreement** form must be duly completed and attached to this application.
- Note:** The duly completed Identity Verification Supplementary Form (08295E) and the supporting documents requested on that form must be attached to the application in the following situation:
- a) the policyowner is a corporation, trust or other entity; and
 - b) life insurance coverage with cash surrender values or a savings component is applied for.

Policyowners

<p>X _____ Signature of policyowner</p> <p>_____ Signed at (city, province or territory)</p>	<p>Check the option that applies:</p> <p><input type="checkbox"/> Policyowner 1 identified in section A1 – Individual</p> <p><input type="checkbox"/> Policyowner identified in section A2 – Individual</p> <p><input type="checkbox"/> Authorized signatory identified in section A3 (corporation, trust or other entity / policyowner of major age who has been declared legally incapable)</p>
<p>X _____ Signature of second policyowner</p> <p>_____ Signed at (city, province or territory)</p>	<p>Check the option that applies:</p> <p><input type="checkbox"/> Policyowner 2 identified in section A1 – Individual</p> <p><input type="checkbox"/> Policyowner identified in section A2 – Individual</p> <p><input type="checkbox"/> Authorized signatory identified in section A3 (corporation, trust or other entity / policyowner of major age who has been declared legally incapable)</p>

Proposed insureds age 18 or older (Quebec) or 16 or older (provinces or territories other than Quebec)

- If the proposed insured is of major age and has been declared legally incapable, the authorized signatory identified in **section A3** must sign on their behalf.

<p>X _____ Signature of proposed insured 1</p> <p>_____ Signed at (city, province or territory)</p>	<p>X _____ Signature of proposed insured 2</p> <p>_____ Signed at (city, province or territory)</p>
<p>_____ Date (yyyy/mm/dd)</p>	<p>_____ Date (yyyy/mm/dd)</p>

SOLO Healthcare coverage: children age 18 or older (Quebec) or 16 or older (provinces or territories other than Quebec)

- If the proposed insured is of major age and has been declared legally incapable, the authorized signatory identified in **section A3** must sign on their behalf.

<p>X _____ Signature of Child 1</p> <p>_____ Signed at (city, province or territory)</p>	<p>X _____ Signature of Child 2</p> <p>_____ Signed at (city, province or territory)</p>
<p>_____ Date (yyyy/mm/dd)</p>	<p>_____ Date (yyyy/mm/dd)</p>
<p>X _____ Signature of Child 3</p> <p>_____ Signed at (city, province or territory)</p>	<p>X _____ Signature of Child 4</p> <p>_____ Signed at (city, province or territory)</p>
<p>_____ Date (yyyy/mm/dd)</p>	<p>_____ Date (yyyy/mm/dd)</p>

N - Statements and authorizations (cont.)

If the proposed insured is **under age 18** (Quebec) or **under age 16** (provinces or territories other than Quebec), the signature of a parent, guardian or legal representative is required.

Person signing: Parent (father or mother) Guardian (Quebec) Legal representative (provinces or territories other than Quebec)

Signing for: Proposed insured 1 Proposed insured 2
 Child 1 Child 2 Child 3 Child 4 (SOLO Healthcare and Children's Life Protection coverages)

First and last names of the person signing for the proposed insured (please print)

X

Signature

Signed at (city, province or territory)

Date (yyyy/mm/dd)

Person signing: Parent (father or mother) Guardian (Quebec) Legal representative (provinces or territories other than Quebec)

Signing for: Proposed insured 1 Proposed insured 2
 Child 1 Child 2 Child 3 Child 4 (SOLO Healthcare and Children's Life Protection coverages)

First and last names of the person signing for the proposed insured (please print)

X

Signature

Signed at (city, province or territory)

Date (yyyy/mm/dd)

Irrevocable beneficiary's and creditor's consent for changes requested in section D

- This section must be completed when a signature is required from an irrevocable beneficiary or a creditor who holds a guarantee on the contract.

Irrevocable beneficiary of the contract: I state that I authorize all changes requested in **section D** of this document, including revoking my designation as irrevocable beneficiary, where applicable.

First and last names

X

Signature

Signed at (city, province or territory)

Date (yyyy/mm/dd)

First and last names

X

Signature

Signed at (city, province or territory)

Date (yyyy/mm/dd)

Creditor who holds a guarantee on the contract: I state that I authorize all changes requested in **section D** of this document.

Name

X

Signature

Signed at (city, province or territory)

Date (yyyy/mm/dd)



Desjardins Insurance refers to Desjardins Financial Security Life Assurance Company.

O - Specific consent

Applicable to Quebec only

When one of our representatives offers you financial products such as insurance and annuities, we wish to obtain from you certain relevant information of a personal and/or financial nature. For specifics on the content of each of these information categories, please read the other side of this page. Please authorize, in the table below, the "Required information categories to be accessed" for which you give consent.

After reading the Notice of specific consent shown on the back, I, the undersigned, agree that the information that Desjardins Financial Security, Financial Services Firm holds concerning me be used at the time of the financial services offer of insurance and annuities.

This consent will be valid until it is cancelled or until the cancellation date indicated below.

Identification and signature – policyowner(s) and proposed insured(s) Note: If the person is of major age and has been declared legally incapable, the authorized signatory identified in section A3 must sign on their behalf.		Required information categories to be accessed and Authorization	
First and last names	Date of birth (yyyy/mm/dd)	Personal <input type="checkbox"/> Yes <input type="checkbox"/> No	Cancellation date (if applicable)
Signature	Date of signature (yyyy/mm/dd)	Financial <input type="checkbox"/> Yes <input type="checkbox"/> No	
X			
First and last names	Date of birth (yyyy/mm/dd)	Personal <input type="checkbox"/> Yes <input type="checkbox"/> No	Cancellation date (if applicable)
Signature	Date of signature (yyyy/mm/dd)	Financial <input type="checkbox"/> Yes <input type="checkbox"/> No	
X			
First and last names	Date of birth (yyyy/mm/dd)	Personal <input type="checkbox"/> Yes <input type="checkbox"/> No	Cancellation date (if applicable)
Signature	Date of signature (yyyy/mm/dd)	Financial <input type="checkbox"/> Yes <input type="checkbox"/> No	
X			
First and last names	Date of birth (yyyy/mm/dd)	Personal <input type="checkbox"/> Yes <input type="checkbox"/> No	Cancellation date (if applicable)
Signature	Date of signature (yyyy/mm/dd)	Financial <input type="checkbox"/> Yes <input type="checkbox"/> No	
X			
First and last names	Date of birth (yyyy/mm/dd)	Personal <input type="checkbox"/> Yes <input type="checkbox"/> No	Cancellation date (if applicable)
Signature	Date of signature (yyyy/mm/dd)	Financial <input type="checkbox"/> Yes <input type="checkbox"/> No	
X			
First and last names	Date of birth (yyyy/mm/dd)	Personal <input type="checkbox"/> Yes <input type="checkbox"/> No	Cancellation date (if applicable)
Signature	Date of signature (yyyy/mm/dd)	Financial <input type="checkbox"/> Yes <input type="checkbox"/> No	
X			

In accordance with the *Act Respecting the Protection of Personal Information in the Private Sector*, you may request access to the information that we hold pertaining to you.

O - Specific consent (cont.)

Notice of specific consent

You are free to grant or refuse this consent

Section 92 of the *Act Respecting the Distribution of Financial Products and Services*

What you must know

- At this date, we hold certain information relating to you.
- We require your consent to allow some of our representatives to have access to this information.
- These representatives will also have access to any update of the information done during the period of validity of the consent.
- These representatives will use the information available **in order to solicit you for the purchase of new financial products and services.**

You are free to set the period of validity of your consent

- If you grant consent for an undetermined period of time, you may at any time terminate it by revoking it. At the end of this form, you will find a revocation notice model that you may use for this purpose or as a basis for preparing your own notice.
- If you wish to grant consent for a limited period of time, you may do so by determining this period yourself. This form provides, in the "Specific consent" section, a place where you may write down the period of validity desired.

The Act Respecting the Distribution of Financial Products and Services gives you important rights.

Without this specific consent, Desjardins Financial Security, Financial Services Firm may not use this information for a purpose other than the purpose for which it was collected. **Desjardins Financial Security, Financial Services Firm cannot compel you to give your consent or refuse to do business with you if you refuse to give it.** Section 94 of the Act protects you. For further information, contact the Autorité des marchés financiers at:

Quebec: 418-525-0337 Montreal: 514-395-0337 Toll-free: 1-877-525-0337

We hold certain information pertaining to you that we have collected when offering financial products and services including insurance, annuities, credit and other related services.

Required information categories to be accessed

Personal: for example, first and last names, date of birth, sex, address, phone number, occupation.

Financial: for example, personal and household income, dependents, other insurance contracts and annuities in force, investments, financial statement and, if a company, statement of assets and liabilities.

Model of revocation of specific consent

First name and last name (please print)			Contract number
Address (No., street, apt.)			Date of birth (yyyy/mm/dd)
City	Province or territory	Postal code	10-digit phone number

I hereby revoke the specific consent given to:

Desjardins Financial Security, Financial Services Firm
200, rue des Commandeurs, Lévis (Québec) G6V 6R2

by the following notice:

On _____
(yyyy/mm/dd)

I, the undersigned, _____, hereby notify you that I am cancelling the specific consent authorizing the communication of my personal information for new purposes.

Consent given to you on: _____
Date of consent (yyyy/mm/dd)

X _____
Signature of policyowner or insured
(or authorized signatory if the person is of major age and has been declared legally incapable)

Signed at (city, province or territory)

Referrals

1			
First and last names		Age	Employer
Spouse's first and last names		Age	First name of children
Address (No., street, apt.)			10-digit phone number
			Home: _____ Cell.: _____
City	Province or territory	Postal code	Work: _____, ext.: _____

2			
First and last names		Age	Employer
Spouse's first and last names		Age	First name of children
Address (No., street, apt.)			10-digit phone number
			Home: _____ Cell.: _____
City	Province or territory	Postal code	Work: _____, ext.: _____

3			
First and last names		Age	Employer
Spouse's first and last names		Age	First name of children
Address (No., street, apt.)			10-digit phone number
			Home: _____ Cell.: _____
City	Province or territory	Postal code	Work: _____, ext.: _____

4			
First and last names		Age	Employer
Spouse's first and last names		Age	First name of children
Address (No., street, apt.)			10-digit phone number
			Home: _____ Cell.: _____
City	Province or territory	Postal code	Work: _____, ext.: _____



Desjardins Insurance refers to Desjardins Financial Security Life Assurance Company.