A step towards peace of mind

Insurance Application
Life, Health and Disability

Desjardins
Insurance
Life • Health • Retirement

1, Complexe Desjardins
Montréal (Québec) H5B 1E2
1-800-278-0669

200, rue des Commandeurs
Lévis (Québec) G6V 6R2
1-800-278-0669

07002E (2025-03)

⚠ 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 40, 42, 43, 45, 46, 47 and 48.**

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).

8- Use **section G - Special instructions** to indicate request backdating, if applicable.

9- If you're **adding one or more insureds to an in-force contract,** see the quick reference available on webi (www.webi.ca).

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Part 1

Reset Print

Contract number:

☐ New business ☐ Request for change(s)

Reference: _____

File concerning financial services including insurance, annuities, credit and related services

A - General information

⚠ **IMPORTANT!**

Any personal information that the proposed insured provides in this application or in any other related questionnaire or form will be disclosed to the policyowner.

A1 - Identification of proposed insureds and policyowners (Individuals)

- If you are applying for Children's Life Protection or SOLO Healthcare for your children, you must complete **section F8.**
- If applying for a life insurance coverage with cash surrender values or a savings component, please fill out **section A3 - Declaration of tax residence** if the policyowner is also the insured.

☐ **Insured 1 only** ☐ **Insured 1 and policyowner 1**	☐ **Insured 2 only** ☐ **Insured 2 and policyowner 2**
First name	First name
Last name	Last name
Last name at birth	Last name at birth
Sex ☐ Female ☐ Male / Status ☐ Preferred (non-smoker) ☐ Regular (smoker)	Sex ☐ Female ☐ Male / Status ☐ Preferred (non-smoker) ☐ Regular (smoker)
Date of birth (yyyy/mm/dd) / Place of birth (country)	Date of birth (yyyy/mm/dd) / Place of birth (country)
⚠ If your country of birth **is not** Canada, specify date of arrival in Canada (yyyy/mm/dd): _____	⚠ If your country of birth **is not** Canada, specify date of arrival in Canada (yyyy/mm/dd): _____
Are you a Canadian citizen or a permanent resident (landed immigrant)? ☐ Yes ☐ No	Are you a Canadian citizen or a permanent resident (landed immigrant)? ☐ Yes ☐ No
If **no,** please state your immigration status and answer the question below: ☐ Refugee ☐ Temporary resident with work permit ☐ Student ☐ Refugee claimant ☐ Other: _____	If **no,** please state your immigration status and answer the question below: ☐ Refugee ☐ Temporary resident with work permit ☐ Student ☐ Refugee claimant ☐ Other: _____
Have you applied for permanent residence? ☐ Yes ☐ No	Have you applied for permanent residence? ☐ Yes ☐ No
Address (No., street, apt.)	Address (No., street, apt.)
City / Province or territory	City / Province or territory
Postal code / Email	Postal code / Email
10-digit phone number Home: _____ Cell.: _____ Work: _____, ext.: _____	10-digit phone number Home: _____ Cell.: _____ Work: _____, ext.: _____
Employer (name and city)	Employer (name and city)
Specific occupation (e.g., building engineer) / Annual income $	Specific occupation (e.g., building engineer) / Annual income $
Do you speak and understand English? ☐ Yes ☐ No If **no,** please specify your language: _____	Do you speak and understand English? ☐ Yes ☐ No If **no,** please specify your language: _____
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.) ☐ Your representative ☐ Another person – please identify this person below:	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.) ☐ Your representative ☐ Another person – please identify this person below:
First name / Last name / Relationship to you	First name / Last name / Relationship to you

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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.

☐ Insured 1 only	☐ Insured 1 and policyowner 1	☐ Insured 2 only	☐ 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$

ⓘ 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 ☐ Female ☐ Male	Email	Specific occupation (e.g., building engineer)
Address (No., street, apt.) ☐ same address as Insured 1			City
Province or territory	Postal code		

10-digit phone number

Home: _____ Cell.: _____

Work: _____, ext.: _____

Do you speak and understand English? ☐ Yes ☐ No

If **no,** please specify your language: _____

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.)

☐ Your representative ☐ Another person – please identify this person below:

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$

ⓘ 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)

ⓘ **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)
			T - -	

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.

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A - General information (cont.)

Identification of authorized signatory

- Please attach the document(s) providing authorization to act by the authorized signatory identified below (i. e.: Power of Attorney or Company Resolution).

First Name	Last Name	Specific occupation (e.g., building engineer)

Address (No., street, apt.)

City	Province or territory	Postal code

A3 - Declaration of tax residence (Policyowner – Individual)

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

ⓘ 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.

Policyowner completing the declaration:

☐ **Policyowner 1** identified in **section A1**

☐ Policyowner identified in **section A2**

☐ **I am a tax resident of Canada.**

☐ **I am a tax resident or a citizen of the United States.**

a) If you check this box, provide your U.S. Taxpayer Identification Number (TIN):

b) If you do not have a TIN, have you applied for one?
☐ Yes ☐ No

c) If you are also a tax resident of Canada, provide your social insurance number (SIN): _____

☐ **I am a tax resident of one or more countries other than Canada or the United States.**

a) If you check this box, provide your countries of tax residence and Taxpayer Identification Numbers (TIN).

Country of tax residence	TIN

b) If you do not have a TIN, explain why by checking one of the following boxes:
☐ I will apply or have applied for a TIN but have not yet received it.
☐ My country of tax residence does not issue TINs to its residents.
☐ Other reason (explain): _____

c) If you are also a tax resident of Canada, provide your social insurance number (SIN): _____

Policyowner completing the declaration:

☐ **Policyowner 2** identified in **section A1**

☐ Policyowner identified in **section A2**

☐ **I am a tax resident of Canada.**

☐ **I am a tax resident or a citizen of the United States.**

a) If you check this box, provide your U.S. Taxpayer Identification Number (TIN):

b) If you do not have a TIN, have you applied for one?
☐ Yes ☐ No

c) If you are also a tax resident of Canada, provide your social insurance number (SIN): _____

☐ **I am a tax resident of one or more countries other than Canada or the United States.**

a) If you check this box, provide your countries of tax residence and Taxpayer Identification Numbers (TIN).

Country of tax residence	TIN

b) If you do not have a TIN, explain why by checking one of the following boxes:
☐ I will apply or have applied for a TIN but have not yet received it.
☐ My country of tax residence does not issue TINs to its residents.
☐ Other reason (explain): _____

c) If you are also a tax resident of Canada, provide your social insurance number (SIN): _____

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A - General information (cont.)

A4 - Verification of policyowner identity (Individual)

Policyowner whose identity is being verified:	Policyowner whose identity is being verified:
☐ **Policyowner 1** identified in **section A1**	☐ **Policyowner 2** identified in **section A1**
☐ Policyowner identified in **section A2**	☐ Policyowner identified in **section A2**
☐ Citizenship card ☐ Driver's licence ☐ Health insurance card* ☐ Passport ☐ Other photo card issued by a government	☐ Citizenship card ☐ Driver's licence ☐ Health insurance card* ☐ Passport ☐ Other photo card issued by a government
* 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 Province, territory or state: _____ Country: _____	Place of issue Province, territory or state: _____ Country: _____
Expiry date (yyyy/mm/dd) (an expired ID is not valid)	Date ID checked (yyyy/mm/dd)
Expiry date (yyyy/mm/dd) (an expired ID is not valid)	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: ☐ Utility bill ☐ Employment Insurance benefit statement ☐ Statement of Old Age Security ☐ Statement of Canada Pension Plan Benefits ☐ Bank or credit card statement (the statement **must not be issued** by a caisse or entity of Desjardins Group) ☐ 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: ☐ Utility bill ☐ Employment Insurance benefit statement ☐ Statement of Old Age Security ☐ Statement of Canada Pension Plan Benefits ☐ Bank or credit card statement (the statement **must not be issued** by a caisse or entity of Desjardins Group) ☐ 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)

A5 - Verification of authorized signatory identity (Policyowner – Corporation, trust or other entity)

ⓘ **The identity of the authorized signatory must be verified using form 08295E if life insurance coverage with cash surrender values or a savings component is applied for.**

☐ Citizenship card ☐ Passport ☐ Driver's licence ☐ Health insurance card* ☐ Other photo card issued by a government

* Cards issued in Manitoba, Ontario, Nova Scotia and Prince Edward Island are not valid for identification purposes.

Place of issue Province, territory or state: _____ Country: _____	Expiry date (yyyy/mm/dd) (an expired ID is not valid)	Date ID checked (yyyy/mm/dd)

A6 - Contingent policyowner

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

☐ **The surviving policyowner** (applies only if there is more than one policyowner) ☐ **The contingent policyowner** named below

First name		Last name	
Date of birth (yyyy/mm/dd)	Sex ☐ Female ☐ Male	10-digit phone number	
Address (No., street, apt.) ☐ same address as Insured 1	City	Province or territory	Postal code

A - General information (cont.)

A7 - 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 Last name			☐ Married ☐ Civil union spouse (Quebec only) ☐ Common-law spouse ☐ Other:	☐ F ☐ M	☐ Revocable ☐ Irrevocable
First name Last name			☐ Married ☐ Civil union spouse (Quebec only) ☐ Common-law spouse ☐ Other:	☐ F ☐ M	☐ Revocable ☐ Irrevocable
Beneficiaries for Insured 2					
First name Last name			☐ Married ☐ Civil union spouse (Quebec only) ☐ Common-law spouse ☐ Other:	☐ F ☐ M	☐ Revocable ☐ Irrevocable
First name Last name			☐ Married ☐ Civil union spouse (Quebec only) ☐ Common-law spouse ☐ Other:	☐ F ☐ M	☐ Revocable ☐ Irrevocable

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 Last name		☐ Married ☐ Civil union spouse (Quebec only) ☐ Common-law spouse ☐ Other:	☐ F ☐ M	☐ Revocable ☐ Irrevocable

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 Last name		☐ Married ☐ Civil union spouse (Quebec only) ☐ Common-law spouse ☐ Other:	☐ F ☐ M	☐ Revocable ☐ Irrevocable

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 Last name			☐ Married ☐ Self ☐ Civil union spouse (Quebec only) ☐ Common-law spouse ☐ Other:	☐ F ☐ M	☐ Revocable ☐ Irrevocable
First name Last name			☐ Married ☐ Self ☐ Civil union spouse (Quebec only) ☐ Common-law spouse ☐ Other:	☐ F ☐ M	☐ Revocable ☐ Irrevocable

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 Last name			☐ Married ☐ Self ☐ Civil union spouse (Quebec only) ☐ Common-law spouse ☐ Other:	☐ F ☐ M	☐ Revocable ☐ Irrevocable
First name Last name			☐ Married ☐ Self ☐ Civil union spouse (Quebec only) ☐ Common-law spouse ☐ Other:	☐ F ☐ M	☐ Revocable ☐ Irrevocable

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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		☐ Revocable ☐ Irrevocable
Name		☐ Revocable ☐ Irrevocable

Death benefit		
Beneficiaries	**%**	**Status**
Name		☐ Revocable ☐ Irrevocable
Name		☐ Revocable ☐ 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 Last name			☐ Married ☐ Self ☐ Civil union spouse (Quebec only) ☐ Common-law spouse ☐ Other:	☐ F ☐ M	☐ Revocable ☐ Irrevocable
First name Last name			☐ Married ☐ Self ☐ Civil union spouse (Quebec only) ☐ Common-law spouse ☐ Other:	☐ F ☐ M	☐ Revocable ☐ Irrevocable

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.

Beneficiaries for Insured 1	**Trustee**	**Trustee's date of birth (yyyy/mm/dd)**	**Relationship between the trustee and the beneficiary**	**Sex**
First name Last name	First name Last name			☐ F ☐ M
First name Last name	First name Last name			☐ F ☐ M
Beneficiaries for Insured 2				
First name Last name	First name Last name			☐ F ☐ M
First name Last name	First name Last name			☐ F ☐ M

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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.** (If you're adding one or more insureds, see the quick reference available on *web*.)
- 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 coverages ☐ Change from regular to preferred rates ☐ Partial replacement

☐ Add insured(s) – Quick reference available on *web* ☐ 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.)

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

[1] 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)[1]	
	From	To

[1] Please be sure to indicate the amount of the deposit on an **annual** basis.

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

- ☐ Add rider
- ☐ Benefit period increase
- ☐ Change from regular to preferred rates
- ☐ Change premium structure from T65 to T10
- ☐ Monthly income benefit increase
- ☐ Occupation class change
- ☐ Occupation class upgrade
- ☐ Review an exclusion or extra premium
- ☐ Waiting period reduction
- ☐ Other: _____

Desjardins Insurance refers to Desjardins Financial Security Life Assurance Company.

E - Eligibility

E1 - Eligibility for SOLO disability coverages

ⓘ 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 25.**
- For SOLO Loan Insurance, please complete **questions 1 to 18.** If you are asking for an occupation class upgrade, also complete **question 19.**
- 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 female, 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:
a) Employment Insurance (EI)? ☐ Yes ☐ No
b) Workers' Compensation Plan - CNESST (formerly the CSST) / WCB / WSIB / WHSCC? ☐ Yes ☐ No

Employment profile

4- Profession or occupation

5- Professional designation/diploma obtained (level of education)

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) Sales		
d) Supervision		
e) Others, specify:		
TOTAL:	100%	
f) Indicate the percentage of time spent travelling outside North America	%	

8- Number of hours worked per week: _____

9- Number of hours worked per week in the **last 4 weeks:** _____

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

11- 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

12- 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: _____
c) Your annual income: $_____

13- Are you planning to change your occupation in the next **6 months?** ☐ Yes ☐ No
If **yes,** indicate the reason:

E - Eligibility (cont.)

E1 - Eligibility for SOLO disability coverages (cont.)

Company/employer profile

14- Name of company	15- Nature of business		
16- Address (No., street, apt.)	City	Province or territory	Postal code
17- Company website			

18- 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 self-employed worker or a business owner, please complete the table below:

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

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

19- Earned income based on your current employment situation

a) ☐ 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) ☐ Self-employed worker paid on commission
c) ☐ Self-employed worker
d) ☐ 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)
$	$	$

e) ☐ 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):

f) ☐ 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.)

20- If you are self-employed, do you split your income for tax purposes? ☐ Yes ☐ No
If **yes,** what is the income splitting amount? $ _____

21- Calculate your unearned income from last year and estimate your unearned income for this year.
Does one of these amounts exceed the lesser of the following: $30,000 or 15% of the income you reported in **question 19?** ☐ 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: investment income, rental or copyrights, etc.)
If **yes,** complete **question 24** - Unearned income sources.

22- Does your net worth (assets minus liabilities) exceed $4,000,000? ☐ Yes ☐ No
If **yes,** complete **question 25** - Net worth.

23- Are you applying for the guaranteed benefit? ☐ Yes ☐ No
If **yes,** financial proof is required to determine eligibility. Please refer to the Representative guide.

24- Unearned income sources (Unearned income sources are excluded from the insurable net earned income declared in **question 19.**)

Net profit from rental income	$
Capital gains	$
Non-professional dividends	$
Interest	$
Other (specify)	$
Total	$

25- 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?	☐ Yes ☐ No	☐ Yes ☐ No
b) covered by the provincial drug insurance plan? If **no,** specify the reason:	☐ Yes ☐ No	☐ Yes ☐ No
c) a pregnant woman? If **yes,** specify the due date (yyyy/mm/dd): _____	☐ Yes ☐ No	☐ Yes ☐ No

Desjardins Insurance refers to Desjardins Financial Security Life Assurance Company.

Desjardins Insurance
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F - Evidence of insurability

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 ☐ Female ☐ Male	Date of birth (yyyy/mm/dd)		Sex ☐ Female ☐ Male	Date of birth (yyyy/mm/dd)	
Height cm / ft in	Weight kg / lbs	Weight 1 year ago kg / lbs	Height cm / ft in	Weight kg / lbs	Weight 1 year ago kg / lbs
Cause of any weight change of 4.5 kg (10 lbs) or more in the last year:			Cause of any weight change of 4.5 kg (10 lbs) or more in the last year:		

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
Does the proposed insured currently have life or critical illness insurance (not including any group insurance coverage)? If **yes,** please complete the table below for each individual insurance coverage held with Desjardins Insurance or another company. (Do not include the coverages applied for in this application.)	☐ Yes ☐ No	☐ Yes ☐ No

Insured 1	Amount $	Name of company	Purpose of insurance	
			Personal	Business
LIFE			☐	☐
			☐	☐
CI			☐	☐
			☐	☐

Insured 2	Amount $	Name of company	Purpose of insurance	
			Personal	Business
LIFE			☐	☐
			☐	☐
CI			☐	☐
			☐	☐

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

Does the proposed insured currently have disability insurance (including any group insurance coverage offered through an employer)? ☐ Yes ☐ No

If **yes,** please complete the table below for each disability insurance coverage held with Desjardins Insurance or another company. (Do not include the coverages applied for in this application.)

If the proposed insured is 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 Type of coverage ☐ Credit insurance (bank/credit union) ☐ Credit insurance (e.g. SOLO Loan) ☐ Group insurance ☐ Individual disability insurance ☐ Overhead expense insurance					☐ Yes ☐ No
Name of insurer Type of coverage ☐ Credit insurance (bank/credit union) ☐ Credit insurance (e.g. SOLO Loan) ☐ Group insurance ☐ Individual disability insurance ☐ Overhead expense insurance					☐ Yes ☐ No
Name of insurer Type of coverage ☐ Credit insurance (bank/credit union) ☐ Credit insurance (e.g. SOLO Loan) ☐ Group insurance ☐ Individual disability insurance ☐ Overhead expense insurance					☐ Yes ☐ No

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F - Evidence of insurability (cont.)

F3 - Identification of the personal physician

- Indicate the contact information of the personal physician who has the medical records of each proposed insured.

Insured 1			**Insured 2** ☐ Same as for Insured 1		
Name of personal physician			Name of personal physician		
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 last visit (yyyy/mm/dd)		10-digit phone number	Date of last visit (yyyy/mm/dd)	
Reason for last visit and results			Reason for last visit and results		

F4 - Examinations ordered by 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	☐	☐	☐	☐	☐	☐	☐	☐
Insured 2	☐	☐	☐	☐	☐	☐	☐	☐

Authorization number for Insured 1 (mandatory): _____

Authorization number for Insured 2 (mandatory): _____

F - Evidence of insurability (cont.)

F5 - Mandatory questions for all proposed insureds

	Insured 1	Insured 2
1- Has the proposed insured submitted this application to replace a life, disability, critical illness or long term care insurance coverage issued by Desjardins Insurance or by another insurer? If **yes,** complete notice or prior notice of replacement.	☐ Yes ☐ No	☐ Yes ☐ No

- The following contract(s) will be cancelled if this application is approved: | | | |

	Insured 1	Insured 2
2- Has the proposed insured submitted one or more life, disability or critical illness insurance applications that are currently under review with Desjardins Insurance or other companies? If **yes,** complete the table below.	☐ Yes ☐ No	☐ Yes ☐ No

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						

	Insured 1	Insured 2
3- In the past **10 years,** has Desjardins Insurance or another company declined an application for life, disability or critical illness insurance for the proposed insured? If **yes,** complete the table below.	☐ Yes ☐ No	☐ Yes ☐ No

	Coverage applied for	Year	Reason for refusal
Insured 1	☐ Life ☐ Disability ☐ Critical illness		
Insured 2	☐ Life ☐ Disability ☐ Critical illness		

	Insured 1	Insured 2
This question is for proposed insureds age 17 or older. 4- Has the proposed insured used any form of **tobacco or nicotine products** (cigarette, cigarillo, cigar, pipe, electronic cigarette, nicotine gum or patches) or anti-smoking medication in the **past 12 months?** If **yes,** complete the table below.	☐ Yes ☐ No	☐ Yes ☐ No

	Type (if cigars, specify type)	Quantity	Frequency of use
Insured 1			☐ Daily ☐ Monthly ☐ Yearly
Insured 2			☐ Daily ☐ Monthly ☐ Yearly

	Insured 1	Insured 2
This question is for proposed insureds age 17 or older. 5- Is the proposed insured a former smoker? If **yes,** complete the table below.	☐ Yes ☐ No	☐ Yes ☐ No

	Date stopped (yyyy/mm/dd)	Past daily use
Insured 1		
Insured 2		

	Insured 1	Insured 2
This question is for proposed insureds age 18 or older. 6- Has the proposed insured declared bankruptcy within the **past 5 years?** If **yes,** complete the table below.	☐ Yes ☐ No	☐ Yes ☐ No

	Date of bankruptcy (yyyy/mm/dd)	Personal	Business	Date of discharge (yyyy/mm/dd)
Insured 1		☐	☐	
Insured 2		☐	☐	

F - Evidence of insurability (cont.)

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 - Supplementary questions

	Insured 1	Insured 2
7- a) Has the proposed insured participated in activities such as flying, skydiving, scuba diving, mountaineering, climbing, off-trail skiing (including heli skiing), motor vehicle racing (including boat racing) or any other hazardous sports over the **past 2 years?** If **yes,** complete the appropriate questionnaire(s) available on web.	☐ Yes ☐ No	☐ Yes ☐ No
b) Is the proposed insured planning to participate in any hazardous sports over the **next 12 months?** If **yes,** complete the appropriate questionnaire(s) available on web.	☐ Yes ☐ No	☐ Yes ☐ No
8- Has the proposed insured been found guilty or accused of a Criminal Code offence within the **past 5 years,** including for driving under the influence of alcohol or drugs? (Answer **yes** if the proposed insured is currently facing charges for a criminal offence or if they are awaiting trial.) If **yes,** complete the table below.	☐ Yes ☐ No	☐ Yes ☐ No

	Date of offence (yyyy/mm)	Type of offence	Date of offence (yyyy/mm)	Type of offence	Driver's licence reinstated (yyyy/mm)
Insured 1					
Insured 2					

	Insured 1	Insured 2
9- Has the proposed insured been found guilty of any traffic offences or a driving infraction that led to the suspension or loss of their driver's licence within the **past 5 years?** If **yes,** complete the table below.	☐ Yes ☐ No	☐ Yes ☐ No

	Date of offence (yyyy/mm)	Type of offence	Km over limit	Date of offence (yyyy/mm)	Type of offence	Km over limit	Driver's licence reinstated (yyyy/mm)
Insured 1							
Insured 2							

	Insured 1	Insured 2
10- In the **next 12 months,** does the proposed insured intend to travel, live or work **outside** Canada or the United States? If **yes,** complete the table below.	☐ Yes ☐ No	☐ Yes ☐ No

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

	Insured 1	Insured 2
11- Has the proposed insured applied for or received disability benefits following an illness or an accident? If **yes,** complete the table below.	☐ Yes ☐ No	☐ Yes ☐ No

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

F - Evidence of insurability (cont.)

F6 - Supplementary questions (cont.)

	Insured 1	Insured 2
12- **Family history** Has the proposed insured reported a history of cancer, heart disease, stroke, high cholesterol, high blood pressure, diabetes, kidney disorders, multiple sclerosis, Huntington's chorea, colon polyps, motor neuron disorder, muscular dystrophy, Parkinson's disease, Alzheimer's disease, cystic fibrosis or any other hereditary disease in their family (father, mother, brothers, sisters)? If **yes,** complete the table below. For all cases of cancer, indicate its location in **section F9 - Explanations**.	☐ Yes ☐ No	☐ Yes ☐ No

Insured 1	Illness(es)	Age at onset of illness	Age if living	Age at death	Cause of death
Father					
Mother					
Brothers					
Sisters					

Insured 2	Illness(es)	Age at onset of illness	Age if living	Age at death	Cause of death
Father					
Mother					
Brothers					
Sisters					

	Insured 1	Insured 2
13- Has the proposed insured ever consulted a healthcare professional, received treatment or undergone surgery or tests involving any of the following? If **yes,** complete the table below and provide relevant details in **section F9 - Explanations.**	☐ Yes ☐ No	☐ Yes ☐ No

	Insured 1	Insured 2		Insured 1	Insured 2
Abnormality of the immune system, including AIDS and positive HIV test	☐	☐	Heart	☐	☐
Alcoholism	☐	☐	Hepatitis	☐	☐
Alzheimer's	☐	☐	High blood pressure	☐	☐
Attention deficit disorder and/or hyperactivity	☐	☐	Hypertriglyceridemia	☐	☐
Backaches	☐	☐	Hypercholesterolemia (high cholesterol)	☐	☐
Blood disorders	☐	☐	Kidney or bladder	☐	☐
Blood vessels	☐	☐	Liver	☐	☐
Brain or neurological disorders	☐	☐	Motor neuron disorder	☐	☐
Breasts	☐	☐	Multiple sclerosis	☐	☐
Burnout	☐	☐	Muscles	☐	☐
Cancer or tumour	☐	☐	Muscular dystrophy	☐	☐
Depression, anxiety, adjustment disorder or other psychological disorder	☐	☐	Musculoskeletal disorders	☐	☐
Diabetes	☐	☐	Optic neuritis	☐	☐
Drug addiction	☐	☐	Parkinson's disease	☐	☐
Ears (including deafness and excluding otitis)	☐	☐	Prostate	☐	☐
Epilepsy, convulsions, dizziness or loss of consciousness	☐	☐	Pulmonary disorders (including sleep apnea)	☐	☐
Eyes (including blindness and excluding myopia and presbyopia)	☐	☐	Sexually transmitted diseases	☐	☐
Gastro-intestinal system	☐	☐	Stroke, transient ischemic attack (TIA), cerebrovascular accident (CVA)	☐	☐
Any other illness not mentioned above:				☐	☐

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F - Evidence of insurability (cont.)

F6 - Supplementary questions (cont.)

	Insured 1	Insured 2
14- Excluding the answers in **question 13,** has the proposed insured ever:		
a) consulted a physician, chiropractor, physiotherapist, psychologist or other healthcare professional for a physical or mental disorder not already mentioned or are they taking medication? If **yes,** please provide more details and the dosage for any medications, if applicable, in section **F9 – Explanations.**	☐ Yes ☐ No	☐ Yes ☐ No
b) had an electrocardiogram, an X-ray, a mammography, an electromyography, a scan, an MRI, blood tests or other diagnostic tests, been hospitalized or undergone surgery? If **yes,** please provide more details in **section F9 – Explanations.**	☐ Yes ☐ No	☐ Yes ☐ No
15- Has the proposed insured ever suffered from, or do they currently have, health-related symptoms, discomforts or signs for which they have not yet consulted a physician, or have they been advised to undergo tests or surgery that have yet to be completed or for which they are currently awaiting the results? If **yes,** please provide more details in section **F9 – Explanations.**	☐ Yes ☐ No	☐ Yes ☐ No
16- Has the proposed insured undergone or been advised to undergo laboratory tests to detect the presence of the AIDS virus or antibodies to the AIDS virus in the **past 5 years?** If **yes,** please provide more details in section **F9 – Explanations.**	☐ Yes ☐ No	☐ Yes ☐ No
17- Has the proposed insured ever used, or do they currently use drugs or narcotics without a medical prescription? If **yes,** complete the drug use questionnaire available on *web*i.	☐ Yes ☐ No	☐ Yes ☐ No
18- a) Has the proposed insured ever consumed, or do they currently consume alcoholic beverages? If **yes,** complete the table below specifying the current weekly consumption and consumption of the **last 3 years** if different.	☐ Yes ☐ No	☐ Yes ☐ No

	Current weekly consumption	Weekly consumption during the last 3 years
Insured 1		
Insured 2		

b) Has the proposed insured undergone or been advised to undergo treatment for alcoholism, been a member of a support group such as Alcoholics Anonymous, or been advised to reduce their alcohol consumption? If **yes,** complete the questionnaire related to alcohol consumption available on *web*i.	☐ Yes ☐ No	☐ Yes ☐ No
19- Has the proposed insured suffered from pain in the cervical, dorsal or lumbar spine or been treated for such pain within the **past 5 years**? If **yes,** complete the back pain or spine impairment questionnaire available on *web*i.	☐ Yes ☐ No	☐ Yes ☐ No

20- **Questions to be answered for SOLO Healthcare only:**

Has the proposed insured:

	Insured		Child			
	1	2	1	2	3	4
a) used any medication for 20 consecutive days or more within the **past 2 years?**	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
b) taken or been advised to use a medication or treatment for a chronic or recurring medical condition or does the proposed insured expect to use any medication or treatment within the **next 3 months?**	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

If **yes,** provide details below:

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

F - Evidence of insurability (cont.)

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 24.		
21- How many siblings are there in the proposed insured's family?		
22- Do **all** of the proposed insured's siblings currently have critical illness insurance? If **no,** please explain why:	☐ Yes ☐ No	☐ Yes ☐ No
23- 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:	☐ Yes ☐ No	☐ Yes ☐ No
24- Does the proposed insured's mother and/or father currently have critical illness insurance?	☐ Yes ☐ No	☐ Yes ☐ No
If **yes,** indicate the insurance amount for each parent with critical illness insurance: **Mother**	$	$
If **no,** please explain why: **Father**	$	$

Medical history	Insured 1	Insured 2
25- Does the proposed insured have, or have they been diagnosed with, or been told they have, symptoms associated with any of the following?		
a) Physical handicap	☐ Yes ☐ No	☐ Yes ☐ No
b) Amyotrophic lateral sclerosis	☐ Yes ☐ No	☐ Yes ☐ No
c) Cystic fibrosis	☐ Yes ☐ No	☐ Yes ☐ No
d) Neurological impairment including autism, cerebral palsy, hyperactivity, attention deficit disorder, developmental delay, Rett's syndrome	☐ Yes ☐ No	☐ Yes ☐ No
If **yes,** please provide details for each health condition in **Section F9 - Explanations.**		
26- 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:	☐ Yes ☐ No	☐ Yes ☐ No

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F - Evidence of insurability (cont.)

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 ☐ Female ☐ Male		Date of birth (yyyy/mm/dd)				Sex ☐ Female ☐ Male		Date of birth (yyyy/mm/dd)			
Height cm	ft in	Weight kg	lbs	Weight 1 year ago kg	lbs	Height cm	ft in	Weight kg	lbs	Weight 1 year ago kg	lbs
Cause of any weight change of 4.5 kg (10 lbs) or more in the last year:						Cause of any weight change 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 ☐ Female ☐ Male		Date of birth (yyyy/mm/dd)				Sex ☐ Female ☐ Male		Date of birth (yyyy/mm/dd)			
Height cm	ft in	Weight kg	lbs	Weight 1 year ago kg	lbs	Height cm	ft in	Weight kg	lbs	Weight 1 year ago kg	lbs
Cause of any weight change of 4.5 kg (10 lbs) or more in the last year:						Cause of any weight change of 4.5 kg (10 lbs) or more in the last year:					

Previous applications for insurance for the children

27- 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?

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

☐ Yes ☐ No

	Coverage applied for	Year	Reason for refusal
Child 1	☐ Life ☐ Healthcare ☐ Critical illness		
Child 2	☐ Life ☐ Healthcare ☐ Critical illness		
Child 3	☐ Life ☐ Healthcare ☐ Critical illness		
Child 4	☐ Life ☐ Healthcare ☐ Critical illness		

F - Evidence of insurability (cont.)

Medical questions for the children to be insured

28- Have any of the children to be insured ever consulted a healthcare professional, received treatment or undergone surgery or tests involving any of the following?

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

☐ Yes ☐ No

	Child					Child			
	1	2	3	4		1	2	3	4
Abnormality of the immune system, including AIDS and positive HIV test	☐	☐	☐	☐	Heart	☐	☐	☐	☐
Alcoholism	☐	☐	☐	☐	Hepatitis	☐	☐	☐	☐
Attention deficit disorder and/or hyperactivity	☐	☐	☐	☐	High blood pressure	☐	☐	☐	☐
Backaches	☐	☐	☐	☐	Hypertriglycerides	☐	☐	☐	☐
Blood disorders	☐	☐	☐	☐	Hypercholesterolemia (high cholesterol)	☐	☐	☐	☐
Blood vessels	☐	☐	☐	☐	Kidney or bladder	☐	☐	☐	☐
Brain or neurological disorders	☐	☐	☐	☐	Liver	☐	☐	☐	☐
Breasts	☐	☐	☐	☐	Motor neuron disorder	☐	☐	☐	☐
Burnout	☐	☐	☐	☐	Multiple sclerosis	☐	☐	☐	☐
Cancer or tumour	☐	☐	☐	☐	Muscles	☐	☐	☐	☐
Depression, anxiety, adjustment disorder or other psychological disorder	☐	☐	☐	☐	Muscular dystrophy	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	Musculoskeletal disorders	☐	☐	☐	☐
Drug addiction	☐	☐	☐	☐	Optic neuritis	☐	☐	☐	☐
Ears (including deafness and excluding otitis)	☐	☐	☐	☐	Pulmonary disorders (including asthma and sleep apnea)	☐	☐	☐	☐
Epilepsy, convulsions, dizziness or loss of consciousness	☐	☐	☐	☐	Sexually transmitted diseases	☐	☐	☐	☐
Eyes (including blindness and excluding myopia and presbyopia)	☐	☐	☐	☐	Stroke, transient ischemic attack (TIA), cerebrovascular accident (CVA)	☐	☐	☐	☐
Gastro-intestinal system	☐	☐	☐	☐	Any other illness not mentioned above:	☐	☐	☐	☐

F9 - Explanations

No.	Name of proposed insured or child to be insured	Illness, diagnosis, surgery, consultation, treatment, medication, dosage, results, date of last epileptic seizure or asthma attack or other important information	Date (yyyy/mm)	Duration	Name and address of physicians, including specialty and hospital (specify if treated in hospital, outpatient clinic or physician's office)

G - Special instructions

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

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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.

ⓘ 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

☐ New contract	Main coverages applied for and names of proposed insureds
☐ Changes to an in-force contract	Contract number

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

Premium: $ _____
Deposit: $ _____
Total annual amount: $ _____

OR

☐ **Monthly** premium and deposit

Premium: $ _____
Deposit: $ _____
Total monthly amount: $ _____

Payment method

⚠ Check **1 box only** to indicate how you want to make your contract's **recurring payments**.

☐ **Pre-authorized debits –** Complete the **Recurring payments** section of the **09312E – Pre-Authorized Debit (PAD) Agreement** form.

☐ **Credit card –** The credit cardholder must call 1-800-278-0669.

Important: To pay by credit card, the payment frequency must be **annual** ($10,000 maximum).
For a contract with ADO, the payment must include **the annual premium and deposit**.

_____ X _____ _____
First and last names of credit cardholder | Signature of credit cardholder | Date (yyyy/mm/dd)

By signing above, I confirm that I am the credit cardholder and I agree to the card being used to pay the amount indicated in this section.

☐ **Cheque –** Please attach a cheque made out to Desjardins Insurance.

Important: To pay by cheque, the payment frequency must be **annual**.

IMPORTANT! Do not check this box if you have already selected another payment method.

☐ **When the contract is delivered** (does not apply when changes to an in-force contract are requested)

⚠ If you choose to pay when the contract is delivered, the proposed insureds will not benefit from the provisional or conditional insurance offered at no cost.

Using the cash surrender value

To use an in-force contract's cash surrender value to pay the premium for the contract, or the premium and the deposit if the contract includes ADO, please provide the following information after you have selected another payment method above:

In-force contract number	Amount	In-force contract number	Amount
	$		$

When the amount of the cash surrender value you want to use runs out, we will collect the amounts needed to cover any premiums due and the amount of any deposit indicated in the **Premium information** section, if applicable, based on the payment method specified above.

Instructions:

Desjardins Insurance
Life • Health • Retirement

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

☐ New contract	Main coverages applied for and names of proposed insureds
☐ Changes to an in-force contract	Contract number

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

Premium: $ _____
Deposit: $ _____
Total annual amount: $ _____

OR

☐ **Monthly** premium and deposit

Premium: $ _____
Deposit: $ _____
Total monthly amount: $ _____

Payment method

⚠ Check **1 box only** to indicate how you want to make your contract's **recurring payments**.

☐ **Pre-authorized debits –** Complete the **Recurring payments** section of the **09312E – Pre-Authorized Debit (PAD) Agreement** form.

☐ **Credit card –** The credit cardholder must call 1-800-278-0669.

Important: To pay by credit card, the payment frequency must be **annual** ($10,000 maximum).
For a contract with ADO, the payment must include **the annual premium and deposit**.

_____ X _____ _____
First and last names of credit cardholder | Signature of credit cardholder | Date (yyyy/mm/dd)

By signing above, I confirm that I am the credit cardholder and I agree to the card being used to pay the amount indicated in this section.

☐ **Cheque –** Please attach a cheque made out to Desjardins Insurance.
Important: To pay by cheque, the payment frequency must be **annual**.

IMPORTANT! Do not check this box if you have already selected another payment method.

☐ **When the contract is delivered** (does not apply when changes to an in-force contract are requested)

⚠ If you choose to pay when the contract is delivered, the proposed insureds will not benefit from the provisional or conditional insurance offered at no cost.

Using the cash surrender value

To use an in-force contract's cash surrender value to pay the premium for the contract, or the premium and the deposit if the contract includes ADO, please provide the following information after you have selected another payment method above:

In-force contract number	Amount	In-force contract number	Amount
	$		$

When the amount of the cash surrender value you want to use runs out, we will collect the amounts needed to cover any premiums due and the amount of any deposit indicated in the **Premium information** section, if applicable, based on the payment method specified above.

Instructions:

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

Desjardins Insurance refers to Desjardins Financial Security Life Assurance Company.

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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.)

I2 - 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.)

I2 - 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 a 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.)

I3 - 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*.

ⓘ 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 <u>without changes</u>,** 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.)

I3 - 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.

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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.

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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**

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

Signed at (city, province or territory)

Policyowners

X _____ Signature of policyowner (Individual) _____ Date (yyyy/mm/dd)

Check the option that applies:
- ☐ **Policyowner 1** identified in **section A1** – Individual
- ☐ Policyowner identified in **section A2** – Individual

X _____ Signature of second policyowner (Individual) _____ Date (yyyy/mm/dd)

Check the option that applies:
- ☐ **Policyowner 2** identified in **section A1** – Individual
- ☐ Policyowner identified in **section A2** – Individual

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

X _____ Signature of proposed insured 1 _____ Date (yyyy/mm/dd)

X _____ Signature of proposed insured 2 _____ 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)

X _____ Signature of Child 1 _____ Date (yyyy/mm/dd)

X _____ Signature of Child 2 _____ Date (yyyy/mm/dd)

X _____ Signature of Child 3 _____ Date (yyyy/mm/dd)

X _____ Signature of Child 4 _____ 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 _____ 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 _____ Date (yyyy/mm/dd)

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.)

Signed at (city, province or territory)

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

X _____ Signature of proposed insured 1 _____ Date (yyyy/mm/dd)

X _____ Signature of proposed insured 2 _____ 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)

X _____ Signature of Child 1 _____ Date (yyyy/mm/dd)

X _____ Signature of Child 2 _____ Date (yyyy/mm/dd)

X _____ Signature of Child 3 _____ Date (yyyy/mm/dd)

X _____ Signature of Child 4 _____ 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 _____ 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 _____ Date (yyyy/mm/dd)

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M - Authorization to disclose supplementary personal information to the representative

This authorization form is not required for an insurance application.

Note: For the purposes of this form, the term "representative" refers to the representative the policyowner does business with.

Proposed insured 1	Proposed insured 2
First and last names	First and last names
Date of birth (yyyy/mm/dd)	Date of birth (yyyy/mm/dd)

1- By signing this authorization form, I authorize Desjardins Insurance to provide my representative and their financial centre administrative staff with supplementary personal information about me that is outside the scope of what is normally provided as part of an insurance application. **I understand that my representative can use this information to recommend an insurance product that may be better suited to my situation or to help explain the underwriting decisions that are made.**

I understand that supplementary personal information may include details about:

a) results from medical exams or lab tests;
b) my health, including specific illnesses or health problems (e.g., mental illnesses, infectious diseases, use of prescription drugs, illicit drugs or alcohol), treatments I've received, or rehabilitation programs I've participated in;
c) my health uncovered in the insurance application process, even if this information was unknown to me at the time I submitted my insurance application;
d) my work history or financial situation;
e) violations of the Highway Safety Code or other similar laws;
f) Criminal Code offences, etc.

2- By signing this authorization form, I understand and acknowledge the following:

a) I have read and understood the nature and scope of this authorization;
b) I authorize Desjardins Insurance to disclose supplementary personal information about myself to my representative and their financial centre administrative staff;
c) Desjardins Insurance reserves the right not to disclose highly confidential personal details to my representative or their financial centre administrative staff;
d) I can revoke this authorization at any time by calling Desjardins Insurance at **1-877-315-8484;**
e) This authorization will remain valid for 60 days after the latest of the following dates:
   - the date on which Desjardins Insurance issues a new insurance contract or amends an in-force contract;
   - the date on which Desjardins Insurance offers to issue a new insurance contract or amend an in-force contract; or
   - the date on which Desjardins Insurance sends me notice that my insurance application has been cancelled, declined or deferred.

The following people have read this authorization before signing it:

- each proposed insured age **14 or older** (Quebec) or **16 or older** (provinces or territories other than Quebec);
- each person authorized to sign on behalf of a proposed insured **under age 14** (Quebec) or **under age 16** (provinces or territories other than Quebec).

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

X _____ _____
Signature of proposed insured 1 — Date (yyyy/mm/dd)

X _____ _____
Signature of proposed insured 2 — Date (yyyy/mm/dd)

Proposed insured **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 for this person.

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

_____ X _____ _____
First and last names of the person signing for proposed insured 1 (please print) — Signature — Date (yyyy/mm/dd)

_____ X _____ _____
First and last names of the person signing for proposed insured 2 (please print) — Signature — Date (yyyy/mm/dd)

A photocopy of this authorization form is as valid as the original. Please return the completed form to Desjardins Insurance by fax at **1-800-941-4861.**

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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 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 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.*

7- 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.

8- The proposed insured acknowledges that they have read **section J - Notice applicable to MIB, LLC.**

9- The policyowner and the proposed insured have read this section before signing it.

10- 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.

11- 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.

12- 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.

13- **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 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.

14- **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 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.

⚠ **Please sign the next page**

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N - Statements and authorizations (cont.)

Signed at (city, province or territory)

Policyowners

X Signature of policyowner _____ Date (yyyy/mm/dd) _____

Check the option that applies:

☐ **Policyowner 1** identified in **section A1 –** Individual ☐ Policyowner identified in **section A2** – Individual
☐ Person authorized to sign on behalf of policyowner identified in **section A2** – Corporation, trust or other entity

X Signature of second policyowner _____ Date (yyyy/mm/dd) _____

Check the option that applies:

☐ **Policyowner 2** identified in **section A1 –** Individual ☐ Policyowner identified in **section A2** – Individual
☐ Person authorized to sign on behalf of policyowner identified in **section A2** – Corporation, trust or other entity

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

X Signature of proposed insured 1 _____ Date (yyyy/mm/dd) _____

X Signature of proposed insured 2 _____ Date (yyyy/mm/dd) _____

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

X Signature of Child 1 _____ Date (yyyy/mm/dd) _____

X Signature of Child 2 _____ Date (yyyy/mm/dd) _____

X Signature of Child 3 _____ Date (yyyy/mm/dd) _____

X Signature of Child 4 _____ Date (yyyy/mm/dd) _____

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 _____ 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 _____ Date (yyyy/mm/dd) _____

Consent for changes requested, if applicable

I, the undersigned, _____, as the

☐ irrevocable beneficiary of the contract ☐ creditor who holds a guarantee on the contract

state that I authorize all changes detailed in **section D** of this document.

X Signature of irrevocable beneficiary _____ Date (yyyy/mm/dd) _____

X Signature of creditor who holds a guarantee on the contract _____

X Signature of irrevocable beneficiary _____ Date (yyyy/mm/dd) _____

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 and insured		**Required information categories to be accessed and client's authorization**	
First and last names	Date of birth (yyyy/mm/dd)	Personal ☐ Yes ☐ No Financial ☐ Yes ☐ No	Cancellation date (if applicable)
Signature X	Date of signature (yyyy/mm/dd)		
First and last names	Date of birth (yyyy/mm/dd)	Personal ☐ Yes ☐ No Financial ☐ Yes ☐ No	Cancellation date (if applicable)
Signature X	Date of signature (yyyy/mm/dd)		
First and last names	Date of birth (yyyy/mm/dd)	Personal ☐ Yes ☐ No Financial ☐ Yes ☐ No	Cancellation date (if applicable)
Signature X	Date of signature (yyyy/mm/dd)		
First and last names	Date of birth (yyyy/mm/dd)	Personal ☐ Yes ☐ No Financial ☐ Yes ☐ No	Cancellation date (if applicable)
Signature X	Date of signature (yyyy/mm/dd)		
First and last names	Date of birth (yyyy/mm/dd)	Personal ☐ Yes ☐ No Financial ☐ Yes ☐ No	Cancellation date (if applicable)
Signature X	Date of signature (yyyy/mm/dd)		
First and last names	Date of birth (yyyy/mm/dd)	Personal ☐ Yes ☐ No Financial ☐ Yes ☐ No	Cancellation date (if applicable)
Signature X	Date of signature (yyyy/mm/dd)		

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.**

Desjardins Insurance
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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
Policyowner's or insured's first name and last name
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

Desjardins Insurance
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P - Representative information and declaration

Compensation: ☐ Career ☐ Accelerated ☐ Not applicable

The representative declares that:

1- the policyowner and proposed insureds have read all the questions in this application and that, to the best of the representative's knowledge, the answers are true and complete;

2- they have seen all the proposed insureds;

3- they have seen all the policyowners (including the persons authorized to sign on behalf of policyowners that are corporations, trusts or other entities) and that they have duly confirmed their identity;

4- they have disclosed or provided in writing to the policyowner the name 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;

5- they have disclosed in writing to the policyowner any conflict of interest relevant to this application;

6- they have completed the Identity Verification Supplementary Form (08295E) and ensured that all the required documents have been attached to the application, 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.

Representative's first name	Representative's last name	Representative code	Field office code
Email		Share %	Check if trainee ☐
Representative's first name	Representative's last name	Representative code	Field office code
Email		Share %	Check if trainee ☐
Representative's first name	Representative's last name	Representative code	Field office code
Email		Share %	Check if trainee ☐

Is the representative the proposed insured or the policyowner?	☐ Yes ☐ No

X _____ _____
Signature of representative — Date (yyyy/mm/dd)

QUEBEC ONLY - If the representative is a trainee, please complete this section.

First name of supervisor	Last name of supervisor	Representative code	Field office code
Email			

X _____ _____
Signature of supervisor (Quebec only) — Date (yyyy/mm/dd)

Desjardins Insurance
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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.