Reset Print

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

Reinstatement Application Request
(Life and critical illness insurance)

Contract number:

Important information

1- Use this form to apply for life or critical illness insurance reinstatement. If there are more than 2 proposed insureds, please fill out an additional form.
2- If you also want to change policyowners, please complete the **Request for Change of Policyowner – 09614A.**
3- If you want to update the payment instructions for the contract, you must provide one of the following: the completed **Pre-Authorized Debit (PAD) Agreement form – 09312E**, a cheque made out to Desjardins Insurance, or you can call 1-800-278-0669 to give us a credit card number.
4- You must give a copy of the **Notice applicable to MIB, LLC** (pages 7 and 9):
   - 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).

Reinstatement rules:

If the contract was terminated less than 2 years ago and this termination was due to lapse, the contract can be reinstated as of the date of written acceptance by Desjardins Insurance, subject to receiving:

a) payment of all premiums owing; and
b) evidence stating that each proposed insured meets Desjardins Insurance's insurability standards.

When a contract reinstatement is made, the return of premiums cannot be reinstated.

Representative information

First and last names of representative(s) (please print)	Representative code	Field office code	% share	Email

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

A - General information

A1 - Policyowner - Individual

Policyowner 1		Policyowner 2	
First name	Last name	First name	Last name
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.: _____	
Date of birth (yyyy/mm/dd)	Specific occupation (e.g., building engineer)	Date of birth (yyyy/mm/dd)	Specific occupation (e.g., building engineer)

Do you speak and understand English?
Policyowner 1: ☐ Yes ☐ No Proposed insured 1: ☐ Yes ☐ No

If **no,** please specify your language and answer the question below: _____

Who is explaining the contents of this form to you in your language?
(**Note:** This person cannot be a policyowner or a beneficiary named in the contract.)
☐ Your representative
☐ Another person – please identify this person below:

First name	Last name	Relationship to you

Do you speak and understand English?
Policyowner 2: ☐ Yes ☐ No Proposed insured 2: ☐ Yes ☐ No

If **no,** please specify your language and answer the question below: _____

Who is explaining the contents of this form to you in your language?
(**Note:** This person cannot be a policyowner or a beneficiary named in the contract.)
☐ Your representative
☐ Another person – please identify this person below:

First name	Last name	Relationship to you

A2 - Policyowner - Corporation, trust or other entity (e.g., Health Priorities - Business)

Note: Please fill out form **08295E** for any life insurance contract 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		Email
Address (No., street, apt.)		City
Province or territory	Postal code	10-digit phone number , ext.:

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A - Informations générales (suite)

Identification of authorized signatory

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

- The declaration of tax residence must be completed by all **policyowners** identified in **section A1** when requesting the reinstatement of a life insurance contract 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 details, please consult documentation on *web*.

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 process your request.

Policyowner 1	**Policyowner 2**
☐ **I am a tax resident of Canada.**	☐ **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 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). 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):	☐ **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). 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):

Country of tax residence	**TIN**

Country of tax residence	**TIN**

A4 - Proposed insureds

	Name of the proposed insured(s)	**Current occupation and annual income**		**Date of birth (yyyy/mm/dd)**	**Current height and weight**	
1			$			
2			$			

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B - Evidence of insurability

B1 - Mandatory questions

	Insured 1	Insured 2
1- 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
2- **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,** please complete the table below. If applicable, indicate where any cancer is located in **section B2** (page 5).	☐ 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
This question is for proposed insureds age 17 or older. 3- 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. 4- 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		

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B - Evidence of insurability (cont.)

	Insured 1	Insured 2
This question is for proposed insureds age 18 or older. 5- 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		☐	☐	

	Insured 1	Insured 2
6- 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 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 available on *web*.	☐ Yes ☐ No	☐ Yes ☐ No
7- Has the proposed insured been found guilty of driving under the influence of alcohol or drugs within the **past 5 years?** (Answer **yes** if they are currently facing charges for this type of offence or they are awaiting trial.) If **yes,** please complete the table below.	☐ Yes ☐ No	☐ Yes ☐ No

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

	Insured 1	Insured 2
8- 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,** please complete the table below.	☐ Yes ☐ No	☐ Yes ☐ No

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

	Insured 1	Insured 2
9- 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		Departure date (yyyy/mm/dd)	Return date (yyyy/mm/dd)	Purpose of trip (e. g., leisure, business, education, family or vacation)
	Country	City			
Insured 1					
Insured 2					

Since the initial insurance application was signed, has the proposed insured:	Insured 1	Insured 2
10- a) ever consumed alcoholic beverages? If **yes,** please complete the table below and specify their current weekly consumption and their consumption during the **last 3 years,** if different.	☐ Yes ☐ No	☐ Yes ☐ No

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

	Insured 1	Insured 2
b) 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,** please complete the **Alcohol Consumption and/or Drug use Questionnaire,** available on *web*.	☐ Yes ☐ No	☐ Yes ☐ No

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B - Evidence of insurability (cont.)

11- ever used drugs or narcotics without a medical prescription? If **yes,** please complete the **Alcohol Consumption and/or Drug use Questionnaire,** available on *web*.	☐ Yes ☐ No	☐ Yes ☐ No
12- ever been treated for drug use or been advised on this subject? If **yes,** please complete the **Alcohol Consumption and/or Drug use Questionnaire,** available on *web*.	☐ Yes ☐ No	☐ Yes ☐ No
13- suffered illnesses or injuries of any kind? If **yes,** please provide relevant details in **section B2.**	☐ Yes ☐ No	☐ Yes ☐ No
14- consulted a physician or a healthcare professionnal, received treatment, been admitted to a healthcare facility or been advised to do so? If **yes,** please provide relevant details in **section B2.**	☐ Yes ☐ No	☐ Yes ☐ No
15- undergone laboratory tests or exams for diagnostic purposes? If **yes,** please provide relevant details in **section B2.**	☐ Yes ☐ No	☐ Yes ☐ No
16- taken medication or followed a diet? If **yes,** please provide relevant details in **section B2.**	☐ Yes ☐ No	☐ Yes ☐ No
17- undergone or been advised to undergo laboratory tests to detect the AIDS virus, antibodies to the AIDS virus or a sexually transmitted disease? If **yes,** please provide relevant details in **section B2.**	☐ Yes ☐ No	☐ Yes ☐ No
18- experienced discomfort, symptoms or signs for which they have not yet consulted a physician or other healthcare professional, or are waiting to consult one, or for which they have been advised to take medication or undergo surgery, tests or exams that have yet to be completed or for which they are currently awaiting results? If **yes,** please provide relevant details in **section B2.**	☐ Yes ☐ No	☐ Yes ☐ No

B2 - Additional information for questions 2, 13, 14, 15, 16, 17 and 18, if applicable.

Insured 1	Insured 2	Date (yyyy/mm/dd)	Reason for consultation: illness, discomfort, symptom, sign, test or medication	Name and address of physician or healthcare facility
☐	☐			
☐	☐			
☐	☐			
☐	☐			

C - Identification of the personal physician

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

Proposed insured 1		**Proposed insured 2** ☐ Same address as Proposed insured 1	
Name of personal physician		Name of personal physician	
Address (No., street, apt.)		Address (No., street, apt.)	
City		City	
Province or territory	Postal code	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	

D – Instructions for deposit withdrawals for a contract with Additional Deposit Option (ADO)

If the amount of the withdrawal included a recurring deposit for ADO, would you like to reinstate the deposit withdrawals, in addition to the premium? ☐ Yes ☐ No

- If **yes,** we will start withdrawing the same amount beginning on the date when your reinstatement request has been processed.
- If **no,** we will stop withdrawing deposits, and the amount of the permitted annual deposit may decrease accordingly.

If you want to change the deposit amount or make a one-time deposit, please fill out form 24311E – Add or change Additional Deposit Option (ADO).

Desjardins Insurance refers to Desjardins Financial Security Life Assurance Company.

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E - 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

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

Who is MIB, LLC?

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- 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.

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

Signed at (city, province or territory)

Policyowners

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

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

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)

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

_____ First and last names of the person signing for 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

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

X _____ Signature

_____ Date (yyyy/mm/dd)

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G - 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**

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G - 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)

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

_____ First and last names of the person signing for 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

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

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

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H - Statements and signatures

1- The policyowner and the proposed insured acknowledge that:

a) The contract associated with this application will be reinstated on the date the application is approved by Desjardins Insurance, provided the following conditions are met:

- all past due premiums are paid; **and**
- there are no changes to the health or lifestyle habits of any of the proposed insureds between the date this application for reinstatement is signed and the date it is approved by Desjardins Insurance.

b) In the event an insured person commits suicide within 2 years of the reinstatement of the contract, Desjardins Insurance will not pay out any insurance amounts under the contract. Desjardins Insurance will only refund the premiums paid since the contract reinstatement date, without interest. The refund will be issued to the beneficiary or beneficiaries designated in the original insurance application or in the most recent document signed by the policyowner for that purpose.

c) Any misrepresentation made by the policyowners or proposed insureds, including the misrepresentation of the use of tobacco or nicotine products, may void the contract.

2- The policyowner also acknowledge that:

- 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 any change in circumstances;
- they will provide Desjardins Insurance any business or trust number missing from **section A2 - Policyowner - Corporation, trust or other entity** (page 1) within 90 days.

3- The proposed insured also acknowledges that they have read **section E - Notice applicable to MIB, LLC** (pages 7 and 9).

4- The proposed insured agrees to thave their personal information on this form, or on any other questionnaire or form relating to it, disclosed to the policyowner.

Note: The duly completed **Identity Verification Supplementary Form (08295E)** and the supporting documents requested on that form must be attached to the reinstatement application in the following situation:

a) the policyowner is a corporation, trust or other entity; **and**
b) the reinstatement of a life insurance coverage with cash surrender values or a savings component is requested.

⚠ _____
Signed at (city, province or territory)

X _____ _____ X _____ _____
Signature of policyowner 1 (Individual) Date (yyyy/mm/dd) Signature of policyowner 2 (Individual) Date (yyyy/mm/dd)

X _____ _____
Signature of the person authorized to sign on behalf of the "Corporation, trust or other entity" policyowner Date (yyyy/mm/dd)

X _____ _____ X _____ _____
Signature of proposed insured 1 Date (yyyy/mm/dd) Signature of proposed insured 2 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)

_____ 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)

Signature of representative

X _____ _____
Signature ☐ Check if trainee 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
Life • Health • Retirement

I - Specific consent

Applicable to Quebec only

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

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

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

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

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
Life • Health • Retirement

I - Specific consent (cont.)

I1 - 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.

I2 - 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.

I3 - 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, Quebec G6V 6R2

by the following notice:

On (yyyy/mm/dd): _____

I, the undersigned, _____, hereby notify you that I am
Policyowner’s or insured’s first name and last name

cancelling the specific consent authorizing the communication of my personal information for new purposes.

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

X _____
Signature of policyowner or insured

Desjardins Insurance refers to Desjardins Financial Security Life Assurance Company.