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

Request for Change Without Evidence

Reset Print

Contract number:	Reference number:

Important information

1- When applying for a conversion, Guaranteed Insurability Benefit/Periodic Purchase Option or a change to a universal life contract, an illustration is required.

2- For conversions and the Guaranteed Insurability Benefit/Periodic Purchase Option, the new coverage will be issued under a new contract.

3- If evidence of insurability is required, please complete the **Insurance Application Life, Health and Disability (07002E).**

4- To change policyowner, please complete the **Change of Policyowner form (09614A).**

5- If the contract has been assigned or if it has an irrevocable beneficiary, please have them sign the Irrevocable beneficiary's and creditor's consent in **section L – Statements and authorizations.**

6- If your client is presently disabled (totally or partially), they cannot exercise the future insurability option or the exchange privilege.

7- If you want to add or modify the Additional Deposit Option (ADO) when you are making a change request, you need to fill out form 24311E or 07002E **in addition to this form**. To determine which additional form you need to fill out, please refer to the **In-force administration** page on *web*.

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Representative information

Compensation: ☐ Career ☐ Accelerated ☐ Not applicable

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

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A - General information

A1 – Identification of policyowners (Individuals)

Policyowner 1		**Policyowner 2** ☐ Same address as **Policyowner 1**	
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	Date of birth (yyyy/mm/dd)	Postal code	Date of birth (yyyy/mm/dd)
Email		Email	
10-digit phone number Home: _____ Cell.: _____ Work: _____, ext.: _____		10-digit phone number Home: _____ Cell.: _____ Work: _____, ext.: _____	
Do you speak and understand English? Policyowner 1: ☐ Yes ☐ No Proposed insured: ☐ Yes ☐ No If **no,** please specify your language and answer the question below:		Do you speak and understand English? Policyowner 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 this form or in the contract for which a change is requested.) ☐ Your representative ☐ Another person – please identify this person 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 this form or in the contract for which a change is requested.) ☐ Your representative ☐ Another person – please identify this person below:	
First name	Last name / Relationship to you	First name	Last name / Relationship to you

A2 - Identification of policyowner (Corporation, trust or other entity)

- Complete form **08295E** if the change requested is for a life insurance contract with cash surrender values or a savings component.

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

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

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B - Declaration of tax residence (Policyowner – Individual)

- When applying for a change to a life insurance coverage with cash surrender values or a savings component, the Declaration of tax residence must be completed.
- 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*.

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). **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):	☐ **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):

C - Changes requested

Please complete a new insurance application to increase the insurance amount, change to the preferred rate or add coverages (other than the Accidental Fracture and Accidental Dismemberment or Loss of use coverages).

Please check appropriate box

☐ Add child to Children's Life Protection coverage in force (or to the Family Solution for Vision contracts) First name / Last name at birth Sex ☐ Female ☐ Male / Date of birth (yyyy/mm/dd)	☐ Decrease amount of insurance to:
	☐ Exercice Reduced Paid-up Option
	☐ Insurability option
	☐ Levelling of costs of insurance – Universal life [1] (Brokerage and Vision "N1")
☐ Add Accidental Fracture coverage or Accidental Dismemberment or Loss of Use coverage	☐ Levelling of costs of insurance – Universal life [1] (State Farm Universal Life Back Book Products)
☐ Cancel coverages or remove insureds	☐ Split of the contract (or contract transfer for Vision contracts)
☐ Cancel indexation	
☐ Change Enriched Death Benefit to Level Death Benefit	☐ Triennal increase (Independent Living – COLA Benefit)
☐ Partial exchange option	☐ Association option
☐ Full exchange option	☐ Other:

[1] **An illustration is required for this change.**

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C - Changes requested (cont.)

Changes requested for Vision contracts only

☐ Change Fixed Death benefit to Increasing Death benefit

☐ Change Increasing Death benefit to Fixed Death benefit

☐ Replace the current solution with one of the contract's other solutions

☐ Unbundling of solution

☐ Replace a solution with a Customized Solution or a Performance Solution

☐ Change to the savings fund

☐ Partial withdrawal ☐ Total withdrawal ☐ Termination

- To transfer saving amounts or change the allocation of investment options, complete the **Change(s) to the savings fund of a Vision contract form (06252E).**

☐ Disability – Income

☐ Change "Ultra" coverage to "Plus" coverage

☐ Change "Plus" coverage to "Basic" coverage

☐ **Conversion of group insurance into individual insurance** (1, 2, 3)

Coverage to be converted: _____

Coverage applied for: _____

Amount of insurance applied for: $ _____

First and last names of dependent children, if applicable:

_____ _____ _____ _____

☐ **Conversion of term individual insurance into permanent individual insurance** (1, 2)

☐ Full conversion:

Coverage applied for: _____

First and last names of proposed insureds: _____ _____

☐ Partial conversion:

Coverage to be converted: _____

Coverage applied for: _____

Amount of insurance applied for: $ _____

First and last names of proposed insureds: _____ _____

Do you want to keep the amount of insurance left after the partial conversion?

☐ Yes, I want to keep the amount of insurance left.

☐ No. I want to end the coverage (additional coverages will also end).

☐ No. I want to end all the contract's coverages.

☐ Children/family coverage conversion:

Coverage applied for: _____

Amount of insurance applied for: $ _____

First and last names of dependent children:

_____ _____ _____ _____

☐ **Guaranteed insurability option** (1, 2)

☐ Guaranteed Insurability Option - Individual/Periodic Purchase Option

Please indicate the event justifying the use of the Guaranteed Insurability Option/Periodic Purchase Option:

☐ Age: _____ ☐ Marriage: _____ (Date of marriage (yyyy/mm/dd))

☐ Birth or adoption of a child: _____ (Name) _____ (Date of birth (yyyy/mm/dd))

☐ Business Insurability Option
Be sure to provide the following information:

- Business financial statements for the last 3 years
- Confirm the insured's share in the company
- Confirm that the company is still the policyowner and that it did not change since the issue

(1) An illustration is required for this change.
(2) The new coverage will be issued under a new contract.
(3) Coverages eligible for group conversion are listed on *web*.

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D - Changes requested for SOLO and Select disability coverages

⚠ **IMPORTANT! Any personal information that the proposed insured provides in sections D, E and F will be disclosed to the policyowner.**

Proposed insured	First name:	Last name:

Please check appropriate box

☐ Increase the waiting period: _____ days
☐ Reduce the monthly benefit: $ _____
☐ Reduce the benefit period: _____ years
☐ Remove a rider (specify which rider): _____
☐ Changing in the premium structure from T10 to T65

For the above changes, you do not have to complete any other questions.

☐ Exercise of the Future Insurability Option

- Please complete **section E** (questions 1 to 19) and **section F,** and provide the financial evidence below if applicable
- To be applied for at least 30 days before the coverage anniversary.

Financial evidence to be provided - SOLO and Select Disability Income				**SOLO Loan Insurance**
	Salaried employees	**Self-employed workers or business owners**		
	Regardless of total of disability benefits	Total of disability benefits ≤ $3,500*	Total of disability benefits ≥ $3,501*	
Without Guaranteed benefit	No financial evidence	No financial evidence	• A/2A : T1 Federal Tax Return from the past 3 years • 3A/4A : T1 Federal Tax Return from the past 2 years • Financial statement from last full year	No financial evidence
With Guaranteed benefit	• A/2A : T1 Federal Tax Return from the past 3 years (or T4) • 3A/4A : T1 Federal Tax Return from the past 2 years (or T4)	• A/2A : T1 Federal Tax Return from the past 3 years • 3A/4A : T1 Federal Tax Return from the past 2 years • Financial statement from last full year		

* The total of disability benefits includes this request and any other disability benefits in force with Desjardins Insurance or other companies identified in **section F.**

Exchange privilege

☐ SOLO Loan Insurance to SOLO Disability Income (Please answer questions 1 to 18 of **section E** and complete **section F.**)
☐ SOLO Disability Income to SOLO Loan Insurance (Please answer questions 1 to 12 of **section E** and complete **section F.)**
☐ SOLO/Select Disability Income to Business Expense (Please answer questions 1 to 19 of **section E** and complete **section F.**)
☐ Business Expense to SOLO/Select Disability Income (Please answer questions 1 to 18 of **section E** and complete **section F.**)

Extension privilege

☐ SOLO/Select Disability Income and SOLO Loan Insurance (Please answer questions 1 to 12 of **section E.**)
☐ Business Expense (Please answer questions 1 to 9 and 13 to 19 of **section E.**)

E - Eligibility for modifications of SOLO and Select disability coverages

Specific situation

1- Are you disabled (partially or totally)? ☐ Yes ☐ No
Note: If you answered **yes** to this question, you are not eligible to exercise the future insurability option or the exchange privilege.

2- If you are a female, are you pregnant? ☐ Yes ☐ No

3- Are you on precautionary cessation of work or on parental leave? ☐ 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) Other, specify:		
Total	**100%**	
f) Indicate the percentage of travel outside of North America:	**%**	

8- Number of hours worked per week: _____

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

DISABILITY

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E - Eligibility for modifications of SOLO and Select disability coverages (cont.)

Company/employer profile

10- Name of company: _____

11- Nature of business: _____

12- 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)

13- 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)
$	$	$

14- If you are self-employed, do you split your income for tax purposes? ☐ Yes ☐ No

If **yes,** what is the income splitting amount? $ _____

15- 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 13**? ☐ Yes ☐ No
(Unearned income is income from sources other than your profession and is income that you still receive even if you were disabled. Example: investment income, rental or copyrights, etc.)

If **yes,** complete **question 17** - Unearned income sources.

16- Does your net worth (assets minus liabilities) exceed $4,000,000? ☐ Yes ☐ No

If **yes,** complete **question 18** - Net Worth.

17- Unearned income sources (Unearned income sources are excluded from the insurable net earned income declared in **question 13.**)

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

18- Net worth

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

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E - Eligibility for modifications of SOLO and Select disability coverages (cont.)

19- Business Expense coverage (proposed insured's share of monthly expenses). For SOLO Agriculture, do not complete items l), m) and n).

a) Rent, hydro, telephone and other public utilities	$	h) Interest expense	$
b) Employee salaries	$	i) Business taxes and licenses	$
c) Cleaning services	$	j) Postage and office supplies	$
d) Professional services of an outside accountant	$	k) Property tax on business site	$
e) Property and casualty insurance premium	$	l) Leasing and amortization of equipment, including vehicle	$
f) Professional dues	$	m) Depreciation of equipment and premises belonging to proposed insured	$
g) Professional liability insurance	$	n) Amortization or regular loan payments, including mortgages	$
o) Periodic repayment of capital under loans taken out for unamortized assets (SOLO Agriculture only)			$

Total of monthly expenses (add both columns): $ 0.00

F - Insurance in force

- To be completed if the changes requested are from **section D**.
- If this section is not completed, your request can be delayed.

SOLO and Select disability coverages

- 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 (excluding this request)
- 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) ☐ Individual disability insurance ☐ Credit insurance (e.g. SOLO Loan) ☐ Overhead expense insurance ☐ Group insurance					☐ Yes ☐ No
Name of insurer Type of coverage ☐ Credit insurance (bank/credit union) ☐ Individual disability insurance ☐ Credit insurance (e.g. SOLO Loan) ☐ Overhead expense insurance ☐ Group insurance					☐ Yes ☐ No
Name of insurer Type of coverage ☐ Credit insurance (bank/credit union) ☐ Individual disability insurance ☐ Credit insurance (e.g. SOLO Loan) ☐ Overhead expense insurance ☐ Group insurance					☐ Yes ☐ No

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

G - Changes requested for SOLO Healthcare coverage

Reduce the Health Plus coverage

☐ Basic plan

Remove a rider (check the rider you want to remove)
Please note that if you remove the Drugs rider, the Dental Care rider will be removed automatically.

☐ Drugs ☐ Dental Care ☐ Hospitalization

Remove an insured

☐ Spouse ☐ Child

Desjardins Insurance refers to Desjardins Financial Security Life Assurance Company.

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H - Designation of beneficiary

H1 - Death

- Please check the option that applies.

☐ This designation applies to all the contract's coverages. ☐ This designation applies to the new coverage 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%.

Important: If the contract already has one or more irrevocable beneficiaries, they must sign the Irrevocable beneficiary's and creditor's consent in **section L – Statements and authorizations**.

Insured's name **Beneficiaries for the insured**		%	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
First name	Last name			☐ Married ☐ Civil union spouse (Quebec only) ☐ Common-law spouse ☐ Other:	☐ F ☐ M	☐ Revocable ☐ Irrevocable

Insured's name **Beneficiaries for the insured**		%	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
First name	Last name			☐ Married ☐ Civil union spouse (Quebec only) ☐ Common-law spouse ☐ Other:	☐ F ☐ M	☐ Revocable ☐ Irrevocable

H2 - Designation of contingent beneficiaries

If a beneficiary named in **section H1 - Death** dies before the insured, the contingent beneficiary named below will replace that beneficiary.

Insured's name **Beneficiaries for the insured**		%	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
First name	Last name			☐ Married ☐ Civil union spouse (Quebec only) ☐ Common-law spouse ☐ Other:	☐ F ☐ M	☐ Revocable ☐ Irrevocable

Insured's name **Beneficiaries for the insured**		%	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
First name	Last name			☐ Married ☐ Civil union spouse (Quebec only) ☐ Common-law spouse ☐ Other:	☐ F ☐ M	☐ Revocable ☐ Irrevocable

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H - Designation of beneficiary (cont.)

H3 - Critical illness

- Please check the option that applies.

☐ This designation applies to all the contract's coverages. ☐ This designation applies to the new coverage 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%.

Important: If the contract already has one or more irrevocable beneficiaries, they must sign the Irrevocable beneficiary's and creditor's consent in **section L – Statements and authorizations**.

Insured's name **Beneficiaries for the insured**		**%**	**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) ☐ Self ☐ Common-law spouse ☐ Other:	☐ F ☐ M	☐ Revocable ☐ Irrevocable
First name	Last name			☐ Married ☐ Civil union spouse (Quebec only) ☐ Self ☐ Common-law spouse ☐ Other:	☐ F ☐ M	☐ Revocable ☐ Irrevocable
First name	Last name			☐ Married ☐ Civil union spouse (Quebec only) ☐ Self ☐ Common-law spouse ☐ Other:	☐ F ☐ M	☐ Revocable ☐ Irrevocable

Insured's name **Beneficiaries for the insured**		**%**	**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) ☐ Self ☐ Common-law spouse ☐ Other:	☐ F ☐ M	☐ Revocable ☐ Irrevocable
First name	Last name			☐ Married ☐ Civil union spouse (Quebec only) ☐ Self ☐ Common-law spouse ☐ Other:	☐ F ☐ M	☐ Revocable ☐ Irrevocable
First name	Last name			☐ Married ☐ Civil union spouse (Quebec only) ☐ Self ☐ Common-law spouse ☐ Other:	☐ F ☐ M	☐ Revocable ☐ Irrevocable

I - 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 H1 - Death** and **H3 - Critical illness,** a trustee may be named for that beneficiary.

Minor beneficiaries	**Trustee(s)**	**Trustee's date of birth (yyyy/mm/dd)**	**Sex**	**Relationship between the trustee and the beneficiary**
First name	First name		☐ F ☐ M	
Last name	Last name			
First name	First name		☐ F ☐ M	
Last name	Last name			
First name	First name		☐ F ☐ M	
Last name	Last name			

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J - Paying for the insurance

J1 - Contract payment

Premium information

For a contract without the Additional Deposit Option (ADO)

☐ Annual premium: $_____ ☐ Semi-annual premium $_____ ☐ 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)

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J - Paying for the insurance (cont.)

J2 - Other payment or reimbursement

- Complete this section to make a one-time payment or reimbursement for the contract.

Payment or reimbursement type	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.

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

ⓘ This consent applies to:
- each **policyowner (Individual)**
- the **proposed insured** (only if the change requested in this form applies to a SOLO or Select disability coverage)

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 section L – Statements and authorizations (page 14), 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

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L - Statements and authorizations

1- The policyowner and the proposed insured declare that all answers provided in this form are true and complete.
2- The policyowner agrees to modify their contract based on the information provided in this form.
3- **If a new contract is issued as the result of a modification and this form is signed in Quebec:** the policyowner understands that they could receive a French version of all the documents forming their new contract and asks that these documents and any future documents regarding this new contract be provided to them in English.
Si un nouveau contrat est établi à la suite d'une modification et que le présent document est signé au Québec : le preneur comprend qu'il pourrait recevoir une version française de tous les documents qui constituent son nouveau contrat et demande que ces documents et tout document futur relatif à ce nouveau contrat lui soient fournis en anglais.
4- The proposed insured agrees to have their personal information on this form disclosed to the policyowner.
5- The proposed insured agrees to have insurance issued on them.
6- The policyowner acknowledges 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.
7- The policyowner (Individual) and the proposed insured give their consent regarding the content of **section K - Consent related to the management of your personal information by Desjardins Group** (page 13).

X _____ Signature of policyowner 1 (Individual) | _____ Signed at (city, province or territory) | _____ Date (yyyy/mm/dd)

X _____ Signature of policyowner 2 (Individual) | _____ Signed at (city, province or territory) | _____ Date (yyyy/mm/dd)

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

Signature of the proposed insured (SOLO and Select disability coverages only)

X _____ Signature of proposed insured | _____ Signed at (city, province or territory) | _____ Date (yyyy/mm/dd)

Irrevocable beneficiary's and creditor's consent

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

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

_____ First and last names | X _____ Signature | _____ Signed at (city, province or territory) | _____ Date (yyyy/mm/dd)

_____ First and last names | X _____ Signature | _____ Signed at (city, province or territory) | _____ Date (yyyy/mm/dd)

Creditor who holds a guarantee on the contract: I state that I authorize all changes requested in this form.

_____ Name | X _____ Signature | _____ Signed at (city, province or territory) | _____ 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)

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M - Special instructions

- Provide additionnal details relevant to the request for change.

Desjardins Insurance refers to Desjardins Financial Security Life Assurance Company.

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N - 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	Cancellation date (if applicable)
Signature X	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 X	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 X	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 X	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 X	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 X	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.**

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N - 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
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