




Provisional or conditional insurance

PROVISIONAL LIFE INSURANCE AGREEMENT

If we need to further review the coverages requested in the illustration, each person for whom one or more coverages that pay an amount upon death have been requested will be covered under the Provisional life insurance at no cost. These coverages are also indicated in the Coverage(s) section of the insurance application.

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

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 insurance 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 insurance 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 insurance 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 insurance application is closed.
- 4- Automatically, on the 91st day after the date the insurance application is signed.

Policyowner statement

The policyowner confirms that they have read the Provisional life insurance agreement and that they agree to all the applicable conditions, limitations and exclusions.



Provisional or conditional insurance (cont.)

PROVISIONAL CRITICAL ILLNESS INSURANCE AGREEMENT

If we need to further review the coverages requested in the illustration, 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. These coverages are also indicated in the Coverage(s) section of the insurance application.

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 insurance application is signed, the premium payment information must be provided in the **Paying for the insurance** section of the insurance application.

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 insurance 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**.



Provisional or conditional insurance (cont.)

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 insurance 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 insurance 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 insurance 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 insurance application is closed.
- 5- Automatically, on the 91st day after the date the insurance application is signed.


Policyowner statement


The policyowner confirms that they have read parts 1 and 2 of the Provisional critical illness insurance agreement and that they agree to all the applicable conditions, limitations and exclusions.



Provisional or conditional insurance (cont.)

CONDITIONAL DISABILITY INSURANCE AGREEMENT – SOLO Disability Income

The [SOLO Disability Income sample contract](#) rounds out the Conditional disability insurance agreement. Your representative will describe and provide you with a copy of the sample contract (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 Disability Income 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 Disability Income 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 insurance 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 insurance application is signed, the premium payment information must be provided in the **Paying for the insurance** section of the insurance application.
- 2- We must approve the coverages requested in the illustration* with or without changes (see the **Approval of coverages requested with or without changes** section below).
 - * The coverages requested in the illustration are also indicated in the **Coverage(s)** section of the insurance application.
- 3- The **accident** that causes the insured person's *disability* must occur:
 - a) after the insurance 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 insurance 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 insurance 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 insurance application.

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

- any *accident* that may occur after the insurance application is signed; and
- any *illness* that may occur after the insured person has answered all the insurability questions and undergone all the required examinations and/or tests.

- 1- **When we approve the coverages requested without changes**, this means that we will cover the insured person in the event of a *disability* as set out in the contract to be issued.


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



Provisional or conditional insurance (cont.)

CONDITIONAL DISABILITY INSURANCE AGREEMENT – SOLO Disability Income (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 insurance 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** to understand:

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

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


Policyowner statement


The policyowner confirms that they have read the Conditional disability insurance agreement and the SOLO Disability Income sample contract.



Provisional or conditional insurance (cont.)

CONDITIONAL DISABILITY INSURANCE AGREEMENT – SOLO Loan Insurance

The [SOLO Loan Insurance sample contract](#) rounds out the Conditional disability insurance agreement. Your representative will describe and provide you with a copy of the sample contract (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 Loan Insurance 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 Loan Insurance 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 insurance 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 insurance application is signed, the premium payment information must be provided in the **Paying for the insurance** section of the insurance application.
- 2- We must approve the coverages requested in the illustration* with or without changes (see the **Approval of coverages requested with or without changes** section below).
 - * The coverages requested in the illustration are also indicated in the **Coverage(s)** section of the insurance application.
- 3- The **accident** that causes the insured person's *disability* must occur:
 - a) after the insurance 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 insurance 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 insurance 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 insurance application.

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

- any *accident* that may occur after the insurance application is signed; and
- any *illness* that may occur after the insured person has answered all the insurability questions and undergone all the required examinations and/or tests.

- 1- **When we approve the coverages requested without changes**, this means that we will cover the insured person in the event of a *disability* as set out in the contract to be issued.


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



Provisional or conditional insurance (cont.)

CONDITIONAL DISABILITY INSURANCE AGREEMENT – SOLO Loan Insurance (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 insurance 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 Loan Insurance sample contract** to understand:

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

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

Policyowner statement

The policyowner confirms that they have read the Conditional disability insurance agreement and the SOLO Loan Insurance sample contract.



Notice applicable to MIB, LLC – Give to proposed insured

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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- 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



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**



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

Policyowners

First and last names of policyowner (Individual)  **X** Signature _____ Signed at (city or town, province or territory) _____ Date (yyyy/mm/dd) _____

First and last names of policyowner (Individual)  **X** Signature _____ Signed at (city or town, province or territory) _____ Date (yyyy/mm/dd) _____

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

First and last names of proposed insured  **X** Signature _____ Signed at (city or town, province or territory) _____ Date (yyyy/mm/dd) _____


First and last names of proposed insured  **X** Signature _____ Signed at (city or town, province or territory) _____ Date (yyyy/mm/dd) _____

First and last names of proposed insured  **X** Signature _____ Signed at (city or town, province or territory) _____ Date (yyyy/mm/dd) _____


First and last names of proposed insured  **X** Signature _____ Signed at (city or town, province or territory) _____ Date (yyyy/mm/dd) _____

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

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


First and last names of proposed insured _____ First and last names of the person signing for the proposed insured  **X** Signature _____ Signed at (city or town, province or territory) _____ Date (yyyy/mm/dd) _____

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

First and last names of proposed insured _____ First and last names of the person signing for the proposed insured  **X** Signature _____ Signed at (city or town, province or territory) _____ Date (yyyy/mm/dd) _____



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.
- Use the personal information in your application to assess your insurability. The assessment may be automated to speed up processing. Your personal information may be analyzed to develop or improve statistical models. No insurance can be denied based on the automated assessment alone.

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



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

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

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

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

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

_____	_____	X	_____	_____
First and last names of proposed insured	First and last names of the person signing for the proposed insured	Signature	Signed at (city or town, province or territory)	Date (yyyy/mm/dd)

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

_____	_____	X	_____	_____
First and last names of proposed insured	First and last names of the person signing for the proposed insured	Signature	Signed at (city or town, province or territory)	Date (yyyy/mm/dd)



Statements and authorizations

- 1- The policyowner and the proposed insured declare that all answers and statements provided in this insurance 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 insurance 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 insurance 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) if applicable, they will pay the premium retroactive to the date indicated under "Saving the age" in the **Paying for the insurance** of the insurance application. They understand that the proposed insured(s) will not be covered by the coverages applied for starting on this date;
 - e) 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;
 - f) they will provide Desjardins Insurance any business or trust number missing from the **Owner(s)** section of the insurance application within 90 days;
 - g) 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;
 - h) 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- By signing below, the policyowner:
- a) understands that they will receive a French version of all the documents forming their contract, if the contract is issued; and
 - b) asks that these documents and any future documents regarding the insurance applied for be provided to them in English.
- En signant ci-dessous, le preneur :
- a) comprend qu'il recevra une version française de tous les documents qui constituent son contrat, si ce dernier est établi; et
 - b) 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 the 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 and Part 2 – Definition of covered conditions of the Provisional critical illness insurance agreement set out in the **Provisional or conditional insurance** section of the insurance application.
- 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- If coverages that pay an amount in case of death or critical illness have been requested and the premium payment information is not provided in the **Paying for the insurance** section of the insurance application, the policyowner understands that the proposed insured will not be covered under these coverages or a provisional insurance, if applicable, as of when the insurance application is signed.
- 14- If coverages that pay an amount in case of disability have been requested and the premium payment information is not provided in the **Paying for the insurance** section of the insurance application, the policyowner understands that the proposed insured will not benefit from the advantages of the Conditional disability insurance, if applicable.

Note: If the policyowner is a corporation, trust or other entity:

- a) the person authorized to sign on behalf of the policyowner must sign on the **Signature of the person(s) authorized to sign on behalf of the policyowner** line and indicate their name and title in the section below;
- b) the **Identity Verification Supplementary Form (08295E)** must be completed for life insurance contracts with cash surrender values or a savings component, and the supporting documentation must be attached to the insurance application.



Statements and authorizations (cont.)

Signature of policyowner(s) (policyowner = individual)

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

Signature of the person(s) authorized to sign on behalf of the policyowner (policyowner = corporation, trust or other entity)

_____	X	_____	_____
Title and first and last names of the authorized person	Signature	Signed at (city or town, province or territory)	Date (yyyy/mm/dd)
_____	X	_____	_____
Title and first and last names of the authorized person	Signature	Signed at (city or town, province or territory)	Date (yyyy/mm/dd)

Signature of proposed insured(s)*

_____	X	_____	X	_____
First and last names of the proposed insured	Signature	First and last names of the proposed insured	Signature	Date (yyyy/mm/dd)
_____	X	_____	X	_____
First and last names of the proposed insured	Signature	First and last names of the proposed insured	Signature	Date (yyyy/mm/dd)

*** If the proposed insured is under age 18 (Quebec) or under age 16 (provinces 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 proposed insured	First and last names of the person signing for the proposed insured	Signature	Date (yyyy/mm/dd)
Person signing: <input type="checkbox"/> Parent (father or mother) <input type="checkbox"/> Guardian (Quebec) <input type="checkbox"/> Legal representative (provinces or territories other than Quebec)			

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



Declaration of payor

By signing below, the payor identified in the **Paying for the insurance** section of the insurance application acknowledges that they have read and understood this section. They authorize Desjardins Insurance to debit the required amounts based on the terms and conditions set out in this section.

Pre-authorized debit (PAD) payment

Account holder – Individual

	X		
First and last names of account holder (please print)		Signature of account holder	Date (yyyy/mm/dd)
	X		
First and last names of the second account holder (please print) (only if 2 signatures are required)		Signature of the second account holder	Date (yyyy/mm/dd)

Account holder – Corporation

	X		
First and last names of the person authorized to sign for the corporation		Signature of the person authorized to sign for the corporation	Date (yyyy/mm/dd)

Credit card payment

	X		
First and last names of the credit cardholder (please print)		Signature of the credit cardholder	Date (yyyy/mm/dd)

Declaration of the representative

The representative declares that:

- 1- the policyowners 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 policyowners 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 policyowners 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.

	X		
First and last names of the representative (please print) <input type="checkbox"/> Check if trainee		Representative code	Date (yyyy/mm/dd)
Signature of the representative			

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

	X		
Signature of supervisor			Date (yyyy/mm/dd)



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 page 18. 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 page 18, 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 <input type="checkbox"/> Yes <input type="checkbox"/> No	Cancellation date (if applicable)
Signature X	Date of signature (yyyy/mm/dd)	Financial <input type="checkbox"/> Yes <input type="checkbox"/> No	
First and last names	Date of birth (yyyy/mm/dd)	Personal <input type="checkbox"/> Yes <input type="checkbox"/> No	Cancellation date (if applicable)
Signature X	Date of signature (yyyy/mm/dd)	Financial <input type="checkbox"/> Yes <input type="checkbox"/> No	
First and last names	Date of birth (yyyy/mm/dd)	Personal <input type="checkbox"/> Yes <input type="checkbox"/> No	Cancellation date (if applicable)
Signature X	Date of signature (yyyy/mm/dd)	Financial <input type="checkbox"/> Yes <input type="checkbox"/> No	
First and last names	Date of birth (yyyy/mm/dd)	Personal <input type="checkbox"/> Yes <input type="checkbox"/> No	Cancellation date (if applicable)
Signature X	Date of signature (yyyy/mm/dd)	Financial <input type="checkbox"/> Yes <input type="checkbox"/> No	
First and last names	Date of birth (yyyy/mm/dd)	Personal <input type="checkbox"/> Yes <input type="checkbox"/> No	Cancellation date (if applicable)
Signature X	Date of signature (yyyy/mm/dd)	Financial <input type="checkbox"/> Yes <input type="checkbox"/> No	
First and last names	Date of birth (yyyy/mm/dd)	Personal <input type="checkbox"/> Yes <input type="checkbox"/> No	Cancellation date (if applicable)
Signature X	Date of signature (yyyy/mm/dd)	Financial <input type="checkbox"/> Yes <input type="checkbox"/> No	
First and last names	Date of birth (yyyy/mm/dd)	Personal <input type="checkbox"/> Yes <input type="checkbox"/> No	Cancellation date (if applicable)
Signature X	Date of signature (yyyy/mm/dd)	Financial <input type="checkbox"/> Yes <input type="checkbox"/> 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.



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 _____
Date (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