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

MPORTANT

- · This form must be filled out by the designated beneficiary or, in the absence of a beneficiary, the executor.
- · If the beneficiary is incapacitated or a minor, this form must be filled out by their guardian or representative.
- If there is more than one beneficiary, each must fill out a form.
- Death certificate must be attached to the completed form.
- · You can send us copies of the documents for your claim. If we need the originals, we'll let you know.
- For deaths that occurred outside Canada or the United States, the originals are required.
- · We won't send the originals back to you unless you ask us to in writing.

For internal use							
Last name of first insured		First name of first insured					
		504.11					
FC No.		FSA No.					
Policy No.	Effective date		Sum insured				
			\$				
Please indicate your instructions by selecting one of the following 2 options:							
Send cheque to advisor for delivery							
Send cheque directly to beneficiary(ies)							



(i) We cannot settle this claim unless all questions are answered adequately.

A. Information about the deceased								
Last name		First nam	First name					
Address – No., street, apt.		City	City		Province			
Date of birth (YYYY-MM-DD)	Date of birth (YYYY-MM-DD) Place of birth			Occupation				
Civil status of the deceased:								
Single	Married	☐ Joined in civil u	nion	Common-law spouse	Wido	wed		
Separated - if applicable, with judgment or agreement on (YYYY-MM-DD)								
Divorced on (YYYY-MM-DD)								
Name of surviving spouse:								
Surviving children:	How ma	ny: Age(s):						
Surviving parent(s):	Fath	er Mother Age(s):						
Surviving brother(s) and sister(s): How ma	iny: Age(s):						
Please answer the questions be	low and ente	r the date on which the documen	t was produc	ced (if applicable). Did the deceas	ed have:			
a will*?	a marriage contract?			an act of civil union?		a declaration of heredity*?		
☐ Yes ☐ No		☐ Yes ☐ No		☐ Yes ☐ No		Yes No		
Date (YYYY-MM-DD)		Date (YYYY-MM-DD)		Date (YYYY-MM-DD)		Date (YYYY-MM-DD)		
* See definition on page 5								
1. Date of death (YYYY-MM-DD)		2. Place of death		3. Immediate cause of dea	ath			
4. a) When did the deceased begin to show signs of ill health?								
b) When did the last illness of the deceased begin?								
c) When was a physician consulted, for the first time, as to the last illness of the deceased?								
5. When did the deceased go to work, for the last time, at his usual occupation								
6. Name and address of all physicians who treated the deceased during the last two years								
7. a) Did the deceased ever small	oke?	b) When did the deceased start (YYYY-MM-DD)	to smoke?	c) When did the deceased stop (YYYY-MM-DD)	smoking?	d) Specify non-smoking	g periods	

8. Did the deceased hold other life insurance contracts Yes No If yes, please provide the follow a) with other companies										
Name of life insurance companies	Date of polic	ies Policy nun	nbers	Sums insured						
			\$							
			\$							
			\$							
b) with Desjardins Insurance: Loan insurance with a caisse or credit union:	Yes No									
If yes, name of the institution: Account No.:										
Accirance, Personal Accident Insurance: Yes										
Group insurance with employer: Yes	Group insurance with employer: Yes No									
If yes, name of employer:										
Name of insurance company:			Contr	ract No.:						
Other: Yes No If yes, please specify:										
B. Information about the claimant Last name (or business name)	First name	Date of h	irth (YYYY-MM-DD)	10 digit tolophono Nos						
Last name (or business name)	First name	Date of bi	טט-אוווו (די די ד	10-digit telephone Nos. Home						
Address – No., street, apt.	City	Province	Postal code	Work						
Occupation (or nature of business if an entity)										
Social insurance No. (Required so that any taxable interest	Social insurance No. (Required so that any taxable interest paid to the beneficiary can be reported) Email address									
In what capacity are you requesting payment of the de	ath benefit?									
☐ Designated beneficiary ☐ Executor	of the estate / Liquidator of the suc	ccession								
☐ Spouse ☐ Trustee or	guardian for the minor child									
Administrator of the business – Please specify the adm										
Other, please specify:										
What is your relationship to the deceased?										
☐ Current spouse ☐ Separated spouse										
☐ Child ☐ Parent										
☐ Other (friend, business partner, etc.) – please specify:										
Which settlement option do you wish?	•									
Lump-sum settlement Transfer in an ar	nnuity contract - policy number, if a	pplicable								
C. Information about the executor o	f the estate									
Last name		First name								
Address – No., street, apt.	City	Province	Postal code	10-digit telephone No.						
Email address										
☐ The executor of the estate / liquidator of the succes	sion is also the claimant	☐ I do not know the the exec	utor of the estate / liquid	dator of the succession						

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



Since this claim relates to a deceased person, the personal information required for this consent is that of the deceased person and not the claimant.

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
- Manage your file while you're covered under the insurance
- 3. Process claims

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

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

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

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

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

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

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

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

By signing this form, 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

E. Déclarations

By signing this form:

- I request payment of the policy proceeds and I agree that all written statements of any physician who has examined or treated the deceased, as well as any other supporting document, are an integral part of this claim.
- · I certify that all the answers given above are complete and true.

X Signature of the beneficiary or the executor of the estate / liquidator of the succession X Signature of claimant Date (YYYY-MM-DD) X Signature of witness Date (YYYY-MM-DD)

Definitions

Declaration of heredity (Quebec only)

In the absence of a will, this document is prepared by a notary and identifies the deceased and lists their marital status, matrimonial regime (if applicable) and heirs. It can also serve the secondary purpose of designating a liquidator. It is used by institutions such as banks, Desjardins caisses and insurance companies, as well as government authorities.

Liquidator / Legal personal representative

Person designated by the testator, by the court or, in certain provinces, by the heirs to liquidate a succession.

Will

A revocable act in which a person (called a testator) determines how his or her property will be distributed upon death. Wills must meet the requirements for one of the will types recognized by law, i.e., holograph, in the presence of witnesses or notarial (Quebec only).

Will made in the presence of witnesses

A will:

- · written by the testator or a third party; and
- · dated and signed by the testator or a third party, depending on the province, before 2 or more witnesses.

It must be probated upon the testator's death.

Notarial will (Quebec only)

A will drawn up by a notary and signed by the testator, the notary and a witness. It does not need to be probated.

Holograph will

An entirely handwritten will dated and signed by hand by the testator. No witness is necessary. This type of will must be probated upon the testator's death.

Testator

Person who has made a will.