Desjardins Financial Security®

P.O. Box 3000
Lévis (Québec) G6V 9X8

GROUP INSURANCE - CONTRACT ADMINISTRATION

APPLICATION FOR ENROLMENT OR REQUEST FOR CHANGE(S)

I want to: ☐ **enrol in the group insurance plan** ☐ **modify my group insurance plan**

A - IDENTIFICATION OF EMPLOYER — Please print

Name of employer	Group number	Division number
	F001	

B - IDENTIFICATION OF PARTICIPANT

Last name of participant	First name	Identification or certificate number	Social insurance number

Address - No., street, apt.				
		Date of birth YYYY MM DD	Sex ☐ M ☐ F	Language ☐ English ☐ French
City	Province	Postal code		

Employment status ☐ Permanent ☐ Temporary	I work: ☐ full-time ☐ part time: %	Annual salary	Service or hire date YYYY MM DD	Employee number
Previous employer		Division number	Date of termination of employment YYYY MM DD	

C - PLAN AND COVERAGE SELECTION

PLANS	COVERAGES SELECTED
BASIC DRUG PLAN [A]	☐ Individual ☐ Family ☐ Single-parent [B] ☐ Exemption [C]
BASIC EXTENDED HEALTH PLAN 3 [D]	☐ Individual ☐ Family ☐ Single-parent [B] ☐ Exemption [C]
EXTENDED PLAN 1 [E] DENTAL CARE INSURANCE	☐ Individual ☐ Family ☐ Single-parent [B] ☐ Exemption [C]
EXTENDED PLAN 2 PARTICIPANT BASIC LIFE AND AD&D INSURANCE [F] LONG TERM DISABILITY INSURANCE [F] DEPENDENT LIFE INSURANCE [G] PARTICIPANT ADDITIONAL LIFE AND AD&D INSURANCE	DEPENDENT LIFE INSURANCE [G] IF YOU HAVE APPLIED TO BE EXEMPTED UNDER THE BASIC DRUG PLAN, PLEASE INDICATE YOUR CHOICE: I want to enrol: ☐ Yes ☐ No PARTICIPANT ADDITIONAL LIFE AND AD&D INSURANCE ☐ $5,000 ☐ $50,000 ☐ $10,000 ☐ $75,000 [H] ☐ $15,000 ☐ $100,000 [H] ☐ $25,000 ☐ None

CONTRACT PROVISIONS

A Enrolment in this plan is mandatory.

B Single-parent coverage is only available to participants who do not have a spouse (through marriage, common law or civil union).

C You can be exempted if you are covered under similar insurance benefits elsewhere, even though enrolment in this plan is mandatory.

D Enrolment in this plan is mandatory. The coverage you choose can be the same as the coverage you selected for the Basic Drug Plan, or it can be individual coverage.

However, if you have applied to be exempted from the Basic Drug Plan, you must also apply to be exempted from the Basic Extended Health Plan 3.

E Enrolment in this plan is mandatory if that is what your establishment has chosen.

The selected coverage must be the same as the coverage you selected for the Basic Extended Health Plan 3. If you have applied to be exempted from the Basic Drug Plan and the Basic Extended Health Plan 3, you must still choose coverage under the Extended Plan 1, unless you are covered under similar insurance benefits elsewhere.

F Participant Basic Life and AD&D Insurance, as well as Long Term Disability Insurance, are mandatory, with no right of refusal.

G Dependent Life Insurance is mandatory if you have selected family or single-parent coverage for the Extended Plan 1 or 3.

H Evidence of insurability is required at the time of enrolment if you choose either of these options. Any participants who want to add Participant Additional Life and AD&D Insurance or increase their coverage amount after enrolment must provide evidence of insurability.

D - CHANGES — Check off all plans and coverages selected again.

Please indicate the life event for the requested change(s):

☐ Death
☐ Divorce, separation or end of cohabitation
☐ Children no longer dependent
☐ Spouse eligible for new insurance coverage
☐ Marriage or civil union
☐ Common-law union (at least 12 months)
☐ Termination of spouse's insurance
☐ Birth, adoption or legal custody of a child
☐ Child's return to school
☐ No life event

Life event date YYYY MM DD

E - DESIGNATION OF BENEFICIARY(IES) FOR LIFE INSURANCE BENEFITS — See reverse for information on beneficiary designation

Last name, first name	Relationship	%	Date of birth if minor YYYY MM DD	Please check
				☐ Revocable ☐ Irrevocable
				☐ Revocable ☐ Irrevocable

DESIGNATION OF A TRUSTEE **(Important information on reverse)**

For the province of Québec: The provisions of the Civil Code apply. DO NOT complete this section.
For all other provinces: Complete this section only if you have named a minor beneficiary.

Last and first names of trustee _____ Relationship _____

Address of trustee _____
No., street, apt. City Province Postal code

F - DECLARATION AND AUTHORIZATION FOR THE COLLECTION AND COMMUNICATION OF PERSONAL INFORMATION

I certify that all the information provided herein is complete and true. I acknowledge that all the benefits offered in the contract are subject to the provisions for limitations or reductions as well as to the exclusions stipulated therein. I acknowledge that I have read and received a copy of the information at the back of this form. In the event of death, I expressly authorize my beneficiary(ies), heir(s) or estate liquidator(s) to provide Desjardins Financial Security or its reinsurers with all the information or authorizations deemed necessary to study the claim and obtain the required proofs. This authorization also applies to my minor children, insofar as applicable to this claim. I authorize my employer to deduct the required premium contributions from my salary. I authorize Desjardins Financial Security to use or communicate my social insurance number for administrative purposes. A photocopy of this authorization is as valid as the original.

Signature of participant **Signature of employer's representative** **Date**

WHITE - Desjardins Financial Security YELLOW - Employer PINK - Participant
ELECTRONIC VERSION - Please give a copy to the participant