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

Insurance Application
SOLO Essential Disability Income

Reset Print

☐ New business ☐ Request for change(s)

File concerning financial services including insurance, annuities, credit and related services

Contract number:	Reference number:

Table of contents

A - Proposed insured (the policyowner must be the proposed insured and must be age 18 or older)

First name		Last name	
Last name at birth		Sex ☐ Female ☐ Male	Date of birth (yyyy/mm/dd)
Address (No., street, apt.)		City	
Province	Postal code	Email	

10-digit phone number

Home: _____ Cell.: _____ Work: _____, ext.: _____

Do you speak and understand English? ☐ Yes ☐ No If **no,** please specify your language: _____

If your language is neither English nor French, complete the **Foreign Language Declaration** form available on *web*i.

B - Occupation

- Indicate your occupation by using the exact occupation and industry wording as stated in the Occupation Class List.
- For your responsibilities, please describe your duties: manual or physical, management or clerical, sales, supervisory or other.
- If you have more than one occupation, indicate the riskiest occupational class (class 1 being the least risky).

Do you work in any other occupation more than 15% of your time? ☐ Yes ☐ No

If **no,** indicate your primary occupation. If **yes,** indicate your primary occupation and your secondary occupation(s).

Primary occupation	Description of responsibilities
Secondary occupation	Description of responsibilities

Occupational class: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 5b

Are you covered by any worker's compensation plan? ☐ Yes ☐ No

If you perform driving duties, please answer the following questions.

What type of driver are you? _____

What is your cargo? _____

Do your manual or physical duties represent more than 15% of your job? ☐ Yes ☐ No

C - Pre-requisites for SOLO Essential Disability Income

1- Do you have physical limitations resulting from an injury or a medical condition or are your daily activities currently limited or restricted by an injury or a medical condition? ☐ Yes ☐ No

2- Are you currently working a minimum of 20 hours per week, 35 weeks per year? ☐ Yes ☐ No

3- Are you a Canadian citizen or a permanent resident (Landed Immigrant)? ☐ Yes ☐ No

If you answered **yes** to **question 1** or if you answered **no** to **question 2 or 3,** you are not eligible for this product.

D - Pre-requisites for Illness coverage

Have you ever had any consultations, received any advice, or been treated for the following?

1- Heart attack, stroke or any disease or disorder of the blood vessels of the heart or brain? ☐ Yes ☐ No

2- Parkinson's disease, multiple sclerosis, paralysis, cerebral palsy, Lou Gehrig's disease (amyotrophic lateral sclerosis ALS), Huntington's chorea, muscular dystrophy, Alzheimer's disease, schizophrenia or any brain or nervous system disease or disorder? ☐ Yes ☐ No

3- a) Emphysema, lupus, liver cirrhosis, alcoholic pancreatitis, polycystic kidney disease, cystic fibrosis, AIDS (Acquired Immune Deficiency Syndrome), ARC (Aids-Related Complex)? ☐ Yes ☐ No

b) Have you ever tested positive for the Human Immunodeficiency Virus (HIV) or any disease or disorder of the immune system? ☐ Yes ☐ No

If you answered **yes** to any of these questions, you are not eligible for the Illness coverage of this product.

Please indicate your height: _____ cm or _____ in.	Please indicate your weight: _____ kg or _____ lb

If your weight is less than the minimum, or exceeds the maximum in the Height and Weight Chart for your height, you are not eligible for the Illness coverage.

Height		Minimum weight		Maximum weight	
(ft./in.)	(cm)	(lb)	(kg)	(lb)	(kg)
4' 10'' - 4' 11''	147 - 151	90	40	195	88
5' 0'' - 5' 2''	152 - 158	97	44	205	93
5' 3'' - 5' 4''	159 - 163	105	48	225	102
5' 5'' - 5' 6''	164 - 168	108	49	230	104
5' 7'' - 5' 8''	169 - 173	114	51	245	111
5' 9'' - 5' 10''	174 - 179	120	54	250	113
5' 11'' - 6' 0''	180 - 184	128	58	270	122
6' 1'' - 6' 2''	185 - 189	135	61	280	127
6' 3'' - 6' 4''	190 - 194	143	64	300	136
6' 5'' - 6' 7''	195 - 201	150	68	310	140

E - Eligibility for Illness coverage

E1 - Identification of the personal physician

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

Name of personal physician		Address (No., street, apt.)	
City	Province	Postal code	10-digit phone number
Date of last visit (yyyy/mm/dd)	Reason for last visit and results		

E2 - Family history

Have you ever had in your family (father, mother, brothers, sisters) a history of cancer, polycystic kidney disease, Huntington's chorea or any form of hereditary disease? ☐ Yes ☐ No

If **yes,** please complete the table below.

	Illness(es)	Age at onset of illness	Age if living	Age at death	Cause of death
Father					
Mother					
Brothers					
Sisters					

E - Eligibility for Illness coverage (cont.)

E3 - Alcohol and drug use

Do you consume or use:	If **yes,** indicate weekly consumption.	Was your weekly consumption ever higher during the last 5 years? If **yes,** indicate the past consumption and the reason for the change.
Alcoholic beverages? ☐ Yes ☐ No		☐ Yes ☐ No
Narcotics? ☐ Yes ☐ No		☐ Yes ☐ No
Other drugs? ☐ Yes ☐ No		☐ Yes ☐ No

E4 - Criminal history

Within the past 5 years, have you been convicted or charged with any criminal offence or are charges currently pending? ☐ Yes ☐ No

E5 - Specific medical conditions

1- Have you ever consulted a health care professional, received treatment or undergone surgery or tests involving any of the following? ☐ Yes ☐ No

If **yes,** please complete the table below.

Cancer, tumour (malignant or benign), polyp, cyst or disorder of the lymph glands	☐	Heart trouble (including angina, chest pain, heart murmur)	☐
Diabetes or thyroid dysfunction	☐	Disorder of the ears (including deafness, but excluding otitis)	☐
Chronic headaches, migraines, epilepsy, convulsions, dizziness, syncope or loss of consciousness	☐	Disorder of the breasts, prostate or reproductive organs	☐
Hepatitis	☐	Disorder of the eyes (including blindness and optic neuritis, but excluding myopia and presbyopia)	☐
Transient ischemic attack, high blood pressure or disorder of the circulatory system	☐	Muscle weakness, numbness or tingling of the limbs	☐
Disorder of the spine, neck or back (including pain, sprain, strain, sciatica or disc disease)	☐	Gastrointestinal disorders (including esophagus, stomach, pancreas, intestines, liver or gall bladder), ulcer, internal bleeding or colitis	☐
Disorder of the nose or throat (including loss of speech)	☐	Disorders of the muscles or bones (including arthritis and osteoporosis)	☐
Disorder of the kidneys, bladder, urinary tract or genital organs (including blood or sugar in urine)	☐	Musculoskeletal disorders or disorders of the knee, ankle, foot, hip, wrist, elbow, shoulder or joints (including deformities and amputations)	☐
Tuberculosis, sleep apnea or other sleeping disorder	☐	Pulmonary disorders, bronchitis, persistent or chronic cough, shortness of breath or asthma	☐

2- Are you currently consulting a physician, chiropractor, physiotherapist, psychologist or other health care professional or are you taking medication? ☐ Yes ☐ No

3- Within the past 5 years, have you had health-related symptoms, discomforts or signs for which you have not yet consulted a physician, or have you been advised to undergo tests or surgery that have yet to be performed or for which you are awaiting the results? ☐ Yes ☐ No

4- Within the past 5 years, have you had any illness or injury that resulted in missing more than 10 consecutive days of work? ☐ Yes ☐ No

If you answered **yes** to any question from **sections E4** and **E5,** please give full and accurate details below. Include the question number, symptoms, diagnosis, treatment date, duration of each occurrence and physicians who have treated you. Indicate if any time was lost from work and whether recovery is complete or not. If you are not fully recovered, provide details of any ongoing issues, treatment, problems or follow-ups. Please include details regarding any criminal offence.

No.	Details

F - Examinations ordered by the representative

- If you did not order any examination requirements, please do not complete. For those outside Quebec, please provide the requirements, and complete this section.
- When ordering requirements on a Prestige file, inform the Paramedical provider that it is a Prestige case.

Paramedical firm

☐ Dynacare Insurance Solutions ☐ ExamOne ☐ Other:

Examinations ordered

☐ Paramedical exam ☐ Blood profile ☐ Urine test

G - Annual income

Employee			**Annual income (current year)** $
Worker paid on commission			**Annual income** (Net income reported on your T1: lines 13500 to 14300) $
Self-employed worker or partner: the higher of 100% of (1) or 50% of (2)	**Annual income (1)** (Net income reported on your T1: lines 13500 to 14300) $	**OR**	**Annual gross revenue (2)** (based on the % owned) Business revenue $
Owner of a corporation: the higher of 100% of (1) or 50% of (2)	**Annual business income (1)** (based on the % owned) Annual employment income $ Corporation's profit (or loss) + $ **Total** = $ **0.00**	**OR**	Cost of goods sold - $ Salaries and employee benefits (except for the proposed insured) - $ **Total** = $ **0.00**

Maximum monthly benefit according to the Maximum Monthly Benefit Table	= $	(A)
Total monthly amount of individual or group disability insurance in force (including Desjardins Insurance products)	= $	(B)
Total monthly benefit (A-B)	= $ **0.00**	(C)

H - Insurance in force

Are you submitting this application to replace a coverage issued by Desjardins Insurance or by another insurer? ☐ Yes ☐ No

If **yes,** please complete a notice or prior notice of replacement according to your province's regulations, if required.

Do you have any Accidental Death, Dismemberment or Loss of Use coverage in force? ☐ Yes ☐ No

If **yes,** indicate the total insurance amount that you have. a) With Desjardins Insurance: _____ b) With other insurers: _____

I - Coverages applied for

SOLO Essential Disability Income	Coverage type		Waiting period			Benefit period		Monthly benefit*
	24 hours	Non-work-related	0 days	30 days	120 days	5 years	To age 70	
Accident	☐	☐	☐	☐	☐	☐	☐	$
Illness	☐		☐	☐	☐	☐	☐	$
Accidental Fracture	☐							

Accidental Death, Dismemberment or Loss of Use	☐ $100,000	☐ $200,000	☐ $300,000	☐ $400,000	☐ $500,000

* Available in $100 increments with a required minimum of $500 per month. The monthly benefit cannot exceed the monthly benefit indicated in item (C) of **section G.**

In the case of a request for change, please provide details about the change:

J - Beneficiary for the Accidental Death, Dismemberment or Loss of Use coverage

First and last names of the beneficiary	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 other than Quebec	Sex	Status
		☐ Married ☐ Civil union spouse (Quebec only) ☐ Common-law spouse ☐ Other:	☐ F ☐ M	☐ Revocable ☐ Irrevocable
First and last names of the trustee for a minor beneficiary*	**Date of birth (yyyy/mm/dd)**	**Relationship between the trustee and the beneficiary**	**Sex**	
			☐ F ☐ M	

* For provinces other than Quebec

K - Payment and premium

Premium payment will be done through a "Pre-authorized debit agreement (PAD)". Only a valid personal chequing account can be used. The account holder(s) must sign the "Pre-authorized debit agreement (PAD)" portion of section N on page 9.

Account holder(s) name and account number

Last and first name(s) of account holder(s)			10-digit phone number	
Address (No., street, apt.)	City		Province	Postal code
Name and address of financial institution		Institution number	Transit number	Account number

⚠ **IMPORTANT: Attach a personal cheque marked "VOID" to avoid errors in transcription.**

Authorization of withdrawal

I authorize Desjardins Insurance and the financial institution where I have my account, or any other financial institution I may appoint, to debit the following amount(s) according to my instructions, at the frequency indicated:

☐ Monthly ☐ Semi-annual ☐ Annual

Draw day (select between 1st and 28th): _____ **Amount of premium: $** _____

Waiver

I agree to waive any written notice before the first debit is made or when any change is made to the above debit.

Change or cancellation

I will advise Desjardins Insurance of any changes to this PAD Agreement at least 10 business days prior to the next withdrawal.

I can cancel this PAD Agreement at any time by sending a notice to Desjardins Insurance at least 10 business days prior to the next withdrawal.

I may obtain a sample cancellation form or more information on my right to cancel a PAD Agreement by consulting my financial institution or by visiting www.cdnpay.ca.

The cancellation of this PAD Agreement does not terminate the policyowner's obligations under his contract(s).

Desjardins Insurance can cancel the PAD Agreement by sending a 30-day notice to the policyowner. The PAD Agreement can also be cancelled if the financial institution refuses the pre-authorized debits for any reason.

Reimbursement

I have certain rights of recourse if a PAD does not comply with the terms of this PAD Agreement. For example, I have the right to receive a reimbursement for any PAD that is not authorized or that is not compatible with the terms of this PAD Agreement. For more information on my rights of recourse, I may consult with my financial institution or visit www.cdnpay.ca.

Authorization to collect and communicate personal information

I consent to the disclosure of the personal information in this PAD Agreement to Desjardins Insurance's financial institution and to the holder of the contract(s) paid through this PAD Agreement.

L - Authorization to collect and communicate personal information

For the sole purpose of determining my insurability, managing my file and processing claims, I authorize Desjardins Insurance or its reinsurers:

1- to collect from any individual, legal entity or public or parapublic organization only the personal information they have about me that is needed to process my file. This information may be collected from third parties, including any health care professional or establishment, MIB, Inc., insurance and reinsurance companies, personal information brokers, investigation firms, the policyowner, my employer or my former employers;

2- to disclose to those individuals, legal entities or public or parapublic organizations only the personal information they have about me that is needed to manage my file;

3- to request, if applicable, an investigation report about me and to use the personal information contained in other files it may have that are now closed;

4- to disclose to my personal physician, **section E1** (page 3), any medical information about me that was obtained during the evaluation of my file;

5- to disclose to other insurers or reinsurers any information about me that is relevant to determining my eligibility for insurance;

6- to provide a brief report of my personal information to MIB, Inc., including information on my health.

A photocopy of this authorization is as valid as the original.

X _____ _____

Signature of the proposed insured (policyowner) | Date (yyyy/mm/dd)

M - Notice applicable to MIB, Inc. - Give to policyowner

Information regarding the insurability of the person to be insured will be treated as confidential by Desjardins Insurance, its reinsurers and MIB, Inc., a not-for-profit membership organization of insurance companies that operates an information exchange on behalf of its members. If you submit an application for life or health insurance coverage for an individual or a benefit claim for an insured to another MIB, Inc. member company, upon request, MIB, Inc. will supply such company with the information it has on file about this person.

MIB, Inc. receives personal information for which the collection, use and disclosure is governed by the *Personal Information Protection and Electronic Documents Act* (PIPEDA) and provincial laws. Accordingly, MIB, Inc. has agreed to protect such information in a manner that is substantially similar to Desjardins Insurance's privacy and personal information protection practices and in accordance with applicable laws. As a U.S.-based company, MIB, Inc. is also bound by U.S. laws regarding the disclosure of personal information. If you have any questions about MIB, Inc.'s commitment to ensuring the confidentiality of insureds' personal information, contact the MIB, Inc. Privacy Department at **privacy@mib.com.**

Upon request, MIB, Inc. will disclose all of the information in an insured's file to that insured. Insureds can contact MIB, Inc. at **416-597-0590.** Insureds who dispute the accuracy of the information MIB, Inc. has on record for them can seek a correction in accordance with the procedures set forth on MIB, Inc.'s website at **www.mib.com.** They can also write to MIB, Inc.'s information office at **330 University Avenue, Suite 501, Toronto, Ontario M5G 1R7.**

Desjardins Insurance and its reinsurers can also release information from their files to other insurance companies to which an application for life or health insurance or a benefit claim has been submitted. Consumers can obtain additional information about MIB, Inc. at **www.mib.com.**

Personal information management

Desjardins Insurance handles the personal information it has on you in a confidential manner. Desjardins Insurance keeps this information on file so that you can benefit from the financial services (insurance, annuities, credit, etc.) it offers. This information is consulted solely by Desjardins Insurance employees who need to do so in the course of their work.

You have the right to consult your file. You may also have information corrected if you demonstrate that it is inaccurate, incomplete, ambiguous or not useful. To do so, you must send a written request to the following address: Privacy Officer, Desjardins Insurance, 200, rue des Commandeurs, Levis, Quebec, G6V 6R2.

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 transferred to another country and be subject to the laws of that country. For information about Desjardins Insurance's policies and practices regarding the transfer of personal information outside of Canada, visit the Desjardins Insurance website at **www.desjardinslifeinsurance.com** or write to the Desjardins Insurance Privacy Officer at the address indicated above. The Privacy Officer can also answer any questions about the transfer of personal information to service providers located outside of Canada.

The following paragraph applies only if this form is submitted by a representative of Desjardins Insurance or a representative affiliated with Desjardins Insurance.

Desjardins Insurance can send promotional information or offer new products to individuals whose names appear on its client list. Desjardins Insurance may also give its client list to another component of the Desjardins Group for the same purposes. If you do not want to receive such offers, you may have your name removed from the list by sending a written request to the Privacy Officer at Desjardins Insurance.

Desjardins
Insurance
Life • Health• Retirement

Desjardins Insurance refers to Desjardins Financial Security Life Assurance Company.

Desjardins
Insurance
Life • Health• Retirement

Desjardins Insurance refers to Desjardins Financial Security Life Assurance Company.

N - Statements and authorizations

1- The proposed insured declares that all answers provided in this application, or in any other questionnaire or form relating to it, are true and complete to the best of their knowledge. The same applies to the answers provided during interviews, over the telephone or otherwise, to questions concerning insurability. They understand that Desjardins Insurance will issue the policy based on these answers and statements.

2- The proposed insured agrees to notify Desjardins Insurance of any change that may affect their insurability conditions before the contract is formed. ''Insurability condition'' refers to any situation that may influence Desjardins Insurance's decision such as a change in health status, occupation, lifestyle, smoking habits or tobacco use, an accident, a consultation, examination or treatment by any health care professional, a recommendation to have a medical appointment or consultation with a health care professional that has not yet taken place, a medical test or a recommendation to have a medical test that has not yet been completed, a violation of the Highway Safety Code or other similar laws, a Criminal Code offence, foreign travels or participation in hazardous sports.

3- The proposed insured agrees to have insurance issued on them.

4- The proposed insured acknowledges that:

a) they were given an accurate description of the coverages applied for and their nature;

b) the exclusions and limitations applicable to the coverages were clearly explained;

c) the representative has disclosed or provided in writing to them the name of all life and health insurance companies on whose behalf they sell products, that they receive commissions or salary for the sale of their life and health insurance products and that they may qualify for additional compensation, such as bonuses and non-monetary benefits, like travel incentives.

5- The proposed insured acknowledges that:

a) any misrepresentation may void the policy;

b) they have read the notices in **section M - Notice applicable to MIB, Inc.** and **Personal information management** (page 7), and have received a copy of these notices.

6- The Accident coverage is effective on the date this application is signed by the proposed insured (or, if the application was signed on the 29, 30 or 31st of the month, the 1st of the following month), provided that the initial premium is paid to Desjardins Insurance.

7- If the Illness coverage is submitted on the same date as the Accident coverage, the Illness coverage will be effective on the date it is approved by Desjardins Insurance, provided that the initial premium is paid to Desjardins Insurance and that all conditions for the delivery of the SOLO Essential Disability Income – Illness document are met, including but not limited to, reception and acceptation of all modifications, riders and exclusions required by the policy, signed by the proposed insured within the allotted time given by Desjardins Insurance.

8- In the case of an addition or modification of a coverage on an existing policy, the addition or modification will be effective on the date it is approved by Desjardins Insurance, provided that the premium relative to this addition or modification is paid to Desjardins Insurance and that all conditions for the delivery of the documentation relative to this addition or modification are met, including but not limited to, reception and acceptation of all modifications, riders and exclusions required by the policy, signed by the proposed insured within the allotted time given by Desjardins Insurance.

9- The proposed insured is the policyowner and has read this section before signing it.

X _____ _____ _____

Signature of the proposed insured (policyowner) | Signed at (city or town, province) | Date (yyyy/mm/dd)

Pre-authorized debit agreement (PAD)

I authorize Desjardins Insurance to debit my account held at the financial institution indicated and according to the period and amounts indicated in **section K** of this application. Moreover, I acknowledge having read the terms and conditions regarding the PAD in **section K** of this form and I understand that, to the extent possible, I will receive a copy of the signed authorization. I will not receive any other confirmation prior to the first payment.

X _____ _____

Signature of account holder | Date (yyyy/mm/dd)

X _____ _____

Signature of second account holder (Only if two signatures are required) | Date (yyyy/mm/dd)

Consent for changes requested for an Accidental Death, Dismemberment or Loss of Use coverage, if applicable

I, the undersigned, _____, as the

☐ irrevocable beneficiary of the contract ☐ creditor who holds a guarantee on the contract

state that I authorize all changes detailed in this document.

X _____ X _____

Signature of irrevocable beneficiary | Signature of creditor who holds a guarantee on the contract

X _____ _____

Signature of irrevocable beneficiary | Date (yyyy/mm/dd)

O - Representative information and declaration

Compensation: ☐ Career ☐ Accelerated ☐ Not applicable

The representative declares that:

1- the proposed insured has 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 personally seen the proposed insured;

3- they have disclosed or provided in writing to the proposed insured the name of all life and health insurance companies on whose behalf they sell products, that they receive commissions or salary for the sale of their life and health insurance products and that they may qualify for additional compensation, such as bonuses and non-monetary benefits, like travel incentives;

4- they have disclosed in writing to the proposed insured any conflict of interest relevant to this application.

First name of representative	Last name of representative	Representative code	Field office code
Email		Share %	Check if trainee ☐
First name of representative	Last name of representative	Representative code	Field office code
Email		Share %	Check if trainee ☐
First name of representative	Last name of representative	Representative code	Field office code
Email		Share %	Check if trainee ☐

X _____
Signature of representative

_____
Date (yyyy/mm/dd)

P - 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.

<table>
<tr><th colspan="2">Identification and signature – Proposed insured (policyowner)</th><th colspan="2">Required information categories
to be accessed and client’s authorization</th></tr>
<tr><td>First and last name</td><td>Date of birth (yyyy/mm/dd)</td><td rowspan="2">Personal ☐ Yes ☐ No

Financial ☐ Yes ☐ No</td><td rowspan="2">Cancellation date (if applicable)</td></tr>
<tr><td>Signature

X</td><td>Date of signature (yyyy/mm/dd)</td></tr>
</table>

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.**

P - 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 name, 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	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
Insured's (policyowner'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 insured (policyowner)