A step towards peace of mind

Insurance Application
Life, Health and Disability

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

07002E (2023-03)

⚠ Important information and instructions

1- Before submitting this insurance application to Desjardins Insurance's Head Office, please ensure you have provided all the required information. An incomplete application will delay processing.

2- Use this application when applying for life (traditional and universal), disability, critical illness or health insurance, or to request a change that requires evidence of insurability.
Note: A proposed insured can apply for SOLO Disability Income and/or SOLO Loan Insurance on the same application. If more than one proposed insured is applying for SOLO Disability Income and/or SOLO Loan Insurance, a separate application must be completed for each person.

3- **Do not** use this application for any request for change without evidence of insurability.

4- Ask all the questions in the application that apply to your client and record the answers completely and accurately. **Please ensure all required signatures have been obtained on pages 27, 29, 31, 33, 35, 36 and 37.**

5- Print legibly, preferably in black ink, for photocopying purposes. Do not use ditto marks or liquid paper. Do not erase. If you have a correction to make, strike out the error and have the client initial it.

6- **Ensure the latest version of the illustration software is used to illustrate the elected insurance.** The illustration must be submitted with this application. For universal and participating life coverages, the "Illustration Acknowledgement and Signatures" must also be signed by the policyowner and submitted with the application.

7- **Sections M - Notice applicable to MIB, LLC** and **N - Personal information management** (pages 27 and 28) must be given to the policyowner.

8- Use **section G - Special instructions** (page 20) to indicate request backdating, if applicable.

9- If you're **adding one or more insureds to an existing contract,** see the quick reference available on *webi* (www.webi.ca).

Temporary and conditional insurance agreements

The agreements should **only** be given to the policyowners if:

1- the questionnaire has been completed and signed (pages 31 and 33) and all conditions have been satisfied; and

2- the initial premium has been given with this application.

Table of contents

Part 1

Part 2

Part 3

[1] This section is only required if applying for this coverage.

Desjardins Insurance
Life • Health• Retirement

Part 1

Réinitialiser Imprimer

Contract number:

☐ New business ☐ Request for change(s)

Reference: _____

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

A - General information

A1 - Identification of proposed insureds and policyowners (Individuals)

- If you are applying for Children's Life Protection or SOLO Healthcare for your children, you must complete **section F8** (page 18).
- If applying for a life insurance coverage with cash surrender values or a savings component, please fill out **section A3 - Declaration of tax residence** (page 2) if the policyowner is also the insured.

☐ **Insured 1 only** ☐ **Insured 1 and policyowner 1**	☐ **Insured 2 only** ☐ **Insured 2 and policyowner 2**
First name	First name
Last name	Last name
Last name at birth	Last name at birth
Sex ☐ Female ☐ Male / Status ☐ Preferred (non-smoker) ☐ Regular (smoker)	Sex ☐ Female ☐ Male / Status ☐ Preferred (non-smoker) ☐ Regular (smoker)
Date of birth (yyyy/mm/dd) / Place of birth (country)	Date of birth (yyyy/mm/dd) / Place of birth (country)
⚠ If your country of birth **is not** Canada, specify date of arrival in Canada (yyyy/mm/dd): _____	⚠ If your country of birth **is not** Canada, specify date of arrival in Canada (yyyy/mm/dd): _____
Are you a Canadian citizen or a permanent resident (landed immigrant)? ☐ Yes ☐ No If **no,** please state your immigration status and answer the question below: ☐ Refugee ☐ Temporary resident with work permit ☐ Student ☐ Refugee claimant ☐ Other: _____ Have you applied for permanent residence? ☐ Yes ☐ No	Are you a Canadian citizen or a permanent resident (landed immigrant)? ☐ Yes ☐ No If **no,** please state your immigration status and answer the question below: ☐ Refugee ☐ Temporary resident with work permit ☐ Student ☐ Refugee claimant ☐ Other: _____ Have you applied for permanent residence? ☐ Yes ☐ No
Address (No., street, apt.)	Address (No., street, apt.)
City / Province	City / Province
Postal code / Email	Postal code / Email
10-digit phone number Home: _____ Cell.: _____ Work: _____, ext.: _____	10-digit phone number Home: _____ Cell.: _____ Work: _____, ext.: _____
Employer (name and city)	Employer (name and city)
Specific occupation (e.g., building engineer) / Annual income $	Specific occupation (e.g., building engineer) / Annual income $
Do you speak and understand English? ☐ Yes ☐ No If **no,** please specify your language: _____ Who is explaining the contents of this application to you in your language? (**Note:** This person cannot be a policyowner or a beneficiary named in the application.) ☐ Your representative ☐ Another person – please identify this person below:	Do you speak and understand English? ☐ Yes ☐ No If **no,** please specify your language: _____ Who is explaining the contents of this application to you in your language? (**Note:** This person cannot be a policyowner or a beneficiary named in the application.) ☐ Your representative ☐ Another person – please identify this person below:
First name / Last name / Relationship to you	First name / Last name / Relationship to you

Desjardins Insurance
Life • Health• Retirement

A - General information (cont.)

A2 - Identification of a policyowner who is not a proposed insured

- If there is more than 1 policyowner without coverage, provide the personal details shown below in **section G - Special instructions** (page 20).

Policyowner – Individual

First name	Last name		
Date of birth (yyyy/mm/dd)	Sex ☐ Female ☐ Male	Email	Specific occupation (e.g., building engineer)
Address (No., street, apt.) ☐ same address as Insured 1			City
Province	Postal code		

10-digit phone number

Home: _____ Cell.: _____

Work: _____, ext.: _____

Do you speak and understand English? ☐ Yes ☐ No

If **no,** please specify your language: _____

Who is explaining the contents of this application to you in your language?
(**Note:** This person cannot be a policyowner or a beneficiary named in the application.)

☐ Your representative ☐ Another person – please identify this person below:

First name	Last name	Relationship to you

Policyowner – Corporation, trust or other entity (e.g., Health Priorities - Business, SOLO Loan Insurance)

ⓘ **Note:** Please fill out form **08295E** for life insurance contracts with cash surrender values or a savings component.

Federal business number (all provinces and territories) | **Provincial business number** (Quebec only) | **or** | **Federal trust number** (all provinces and territories) | **Provincial trust number** (Quebec only)

T ____ - ____ - ____

Important: If the business or trust number is missing, the policyowner must provide it to Desjardins Insurance within **90 days.**

Company name			
Address (No., street, apt.)	City	Province	Postal code
Email	10-digit phone number , ext.:		

Does the business carry out activities related to the cannabis industry (cultivation, processing, sales or other related activities)? ☐ Yes ☐ No

If **yes:** Any business that carries out activities related to the cannabis industry must have a **licence from Health Canada.** In some cases, a **licence from the Canada Revenue Agency** is also required.

Important: You must provide us with a copy of your **valid licence(s)** within **90 days** of signing your Application for Insurance, otherwise we won't be able to review your application.

Identification of authorized signatory

- Please attach the document(s) providing authorization to act by the authorized signatory identified below (i. e.: Power of Attorney or Company Resolution).

First Name	Last Name	Specific occupation (e.g., building engineer)
Address (No., street, apt.)		
City	Province	Postal code

A3 - Declaration of tax residence (Policyowner – Individual)

ⓘ **To be completed if applying for a life insurance coverage with cash surrender values or a savings component.**

ⓘ If the policyowner is a corporation, trust or other entity, please fill out form **08295E** for the declaration of tax residence.

For more information, please refer to the documents on *web*.

Note: If there are more than 2 policyowners, provide the details shown below in **section G – Special instructions** (page 20).

Check all the options that apply to your situation and provide all the requested information.
If your declaration is not completed properly, we will not be able to analyze your insurance application.

Policyowner completing the declaration:	Policyowner completing the declaration:
☐ **Policyowner 1** identified in **section A1**	☐ **Policyowner 2** identified in **section A1**
☐ Policyowner identified in **section A2**	☐ Policyowner identified in **section A2**
☐ **I am a tax resident of Canada.**	☐ **I am a tax resident of Canada.**
☐ **I am a tax resident or a citizen of the United States.**	☐ **I am a tax resident or a citizen of the United States.**
a) If you check this box, provide your U.S. Taxpayer Identification Number (TIN): _____	a) If you check this box, provide your U.S. Taxpayer Identification Number (TIN): _____
b) If you do not have a TIN, have you applied for one? ☐ Yes ☐ No	b) If you do not have a TIN, have you applied for one? ☐ Yes ☐ No
c) If you are also a tax resident of Canada, provide your social insurance number (SIN): _____	**c) If you are also a tax resident of Canada, provide your social insurance number (SIN):** _____

Desjardins Insurance
Life • Health• Retirement

A - General information (cont.)

☐ **I am a tax resident of one or more countries other than Canada or the United States.**

a) If you check this box, provide your countries of tax residence and Taxpayer Identification Numbers (TIN).

Country of tax residence	TIN

b) If you do not have a TIN, explain why by checking one of the following boxes:

☐ I will apply or have applied for a TIN but have not yet received it.
☐ My country of tax residence does not issue TINs to its residents.
☐ Other reason (explain): _____

c) If you are also a tax resident of Canada, provide your social insurance number (SIN): _____

☐ **I am a tax resident of one or more countries other than Canada or the United States.**

a) If you check this box, provide your countries of tax residence and Taxpayer Identification Numbers (TIN).

Country of tax residence	TIN

b) If you do not have a TIN, explain why by checking one of the following boxes:

☐ I will apply or have applied for a TIN but have not yet received it.
☐ My country of tax residence does not issue TINs to its residents.
☐ Other reason (explain): _____

c) If you are also a tax resident of Canada, provide your social insurance number (SIN): _____

A4 - Verification of policyowner identity (Individual)

Policyowner whose identity is being verified:
☐ **Policyowner 1** identified in **section A1**
☐ Policyowner identified in **section A2**

☐ Citizenship card ☐ Driver's licence ☐ Health insurance card*
☐ Passport ☐ Other photo card issued by a government

* Cards issued in Manitoba, Ontario, Nova Scotia and Prince Edward Island are not valid for identification purposes.

Place of issue
Province, territory or state: _____
Country: _____

Expiry date (yyyy/mm/dd) (an expired ID is not valid)	Date ID checked (yyyy/mm/dd)

Policyowner whose identity is being verified:
☐ **Policyowner 2** identified in **section A1**
☐ Policyowner identified in **section A2**

☐ Citizenship card ☐ Driver's licence ☐ Health insurance card*
☐ Passport ☐ Other photo card issued by a government

* Cards issued in Manitoba, Ontario, Nova Scotia and Prince Edward Island are not valid for identification purposes.

Place of issue
Province, territory or state: _____
Country: _____

Expiry date (yyyy/mm/dd) (an expired ID is not valid)	Date ID checked (yyyy/mm/dd)

Fill out the following section if life insurance coverage with cash surrender values or a savings component is applied for.

Number of the ID selected above

If the identity is being checked remotely, the policyowner must also show one of the following documents to confirm their name and address:
☐ Utility bill
☐ Employment Insurance benefit statement
☐ Statement of Old Age Security
☐ Statement of Canada Pension Plan Benefits
☐ Bank or credit card statement (the statement **must not be issued** by a caisse or entity of Desjardins Group)
☐ Other document from a reliable source that contains the policyowner's name and address: _____

Name of issuer

Account or reference number

Date of issue (yyyy/mm/dd)

Number of the ID selected above

If the identity is being checked remotely, the policyowner must also show one of the following documents to confirm their name and address:
☐ Utility bill
☐ Employment Insurance benefit statement
☐ Statement of Old Age Security
☐ Statement of Canada Pension Plan Benefits
☐ Bank or credit card statement (the statement **must not be issued** by a caisse or entity of Desjardins Group)
☐ Other document from a reliable source that contains the policyowner's name and address: _____

Name of issuer

Account or reference number

Date of issue (yyyy/mm/dd)

A5 - Verification of authorized signatory identity (Policyowner – Corporation, trust or other entity)

ⓘ **The identity of the authorized signatory must be verified using form 08295E if life insurance coverage with cash surrender values or a savings component is applied for.**

☐ Citizenship card ☐ Passport ☐ Driver's licence ☐ Health insurance card* ☐ Other photo card issued by a government

* Cards issued in Manitoba, Ontario, Nova Scotia and Prince Edward Island are not valid for identification purposes.

Place of issue
Province, territory or state: _____
Country: _____

Expiry date (yyyy/mm/dd) (an expired ID is not valid)	Date ID checked (yyyy/mm/dd)

Desjardins Insurance
Life • Health• Retirement

A - General information (cont.)

A6 - Contingent policyowner

- Upon the death of any policyowner, their rights and interests in the contract will be transferred to:

☐ **The surviving policyowner** (applies only if there is more than one policyowner) ☐ **The contingent policyowner** named below

First name	Last name		
Date of birth (yyyy/mm/dd)	Sex ☐ Female ☐ Male	10-digit phone number	
Address (No., street, apt.) ☐ same address as Insured 1	City	Province	Postal code

A7 - Company's financial position

- To be completed if the insurance elected is considered business insurance (e.g., partnership, key person, business loan):

ⓘ Life insurance: if total amount of insurance in force, including current amount applied for, is **greater than $500,000.**
ⓘ Critical illness insurance: if total amount of insurance in force, including current amount applied for, is **greater than $250,000.**
ⓘ SOLO Loan Insurance: if total amount of insurance in force, including current amount applied for, is **greater than $3,000/month.**

- Provide a financial statement based on the amount of insurance applied for.

Nature of company	Percentage owned by Insured 1 %	Percentage owned by Insured 2 %

Information about the policyowner's company	**Last year**	**Prior to last year**
Assets	$	$
Liabilities	$	$
Net earnings	$	$
Sales figures	$	$
Market value	$	$
Purpose of insurance:	Financial year-end (yyyy/mm/dd):	

Insurance on other partners or officers (include insurance in force or pending)

Name of partners or officers	Ownership %	In force	Pending	Insurance company
		$	$	
		$	$	

B - Beneficiary information

B1 - Death

ⓘ If a contract includes Health Priorities - Business coverage, complete **section B4 - Health Priorities - Business** (page 6) only.

Instructions: Please name the beneficiaries of all amounts payable in the event the insured dies.
E.g., life insurance benefit, premium refund, death benefit not included in a life insurance coverage

- The insured's beneficiary percentages must add up to 100 %.
- If you need more space, use **section G - Special instructions** (page 20).

Beneficiaries for Insured 1	%	**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**
First name Last name			☐ Married ☐ Civil union spouse (Quebec only) ☐ Common-law spouse ☐ Other:	☐ F ☐ M	☐ Revocable ☐ Irrevocable
First name Last name			☐ Married ☐ Civil union spouse (Quebec only) ☐ Common-law spouse ☐ Other:	☐ F ☐ M	☐ Revocable ☐ Irrevocable

B - Beneficiary information (cont.)

Beneficiaries for Insured 2	%	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
First name Last name			☐ Married ☐ Civil union spouse (Quebec only) ☐ Common-law spouse ☐ Other:	☐ F ☐ M	☐ Revocable ☐ Irrevocable
First name Last name			☐ Married ☐ Civil union spouse (Quebec only) ☐ Common-law spouse ☐ Other:	☐ F ☐ M	☐ Revocable ☐ Irrevocable

B2 - Designation of contingent beneficiaries

- If a beneficiary named in **section B1 - Death** (page 4) dies before the insured, the contingent beneficiary named below will replace that beneficiary.

Beneficiary for Insured 1	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
First name Last name		☐ Married ☐ Civil union spouse (Quebec only) ☐ Common-law spouse ☐ Other:	☐ F ☐ M	☐ Revocable ☐ Irrevocable
Beneficiary for Insured 2				
First name Last name		☐ Married ☐ Civil union spouse (Quebec only) ☐ Common-law spouse ☐ Other:	☐ F ☐ M	☐ Revocable ☐ Irrevocable

B3 - Critical illness

ⓘ If a contract includes Health Priorities - Business coverage, complete **section B4 - Health Priorities - Business** (page 6) only.

Instructions: Please name the beneficiaries of all amounts payable in the event the insured has a critical illness covered under a coverage of the contract.
E.g., amount of insurance or advance payable under a critical illness coverage

- The insured's beneficiary percentages must add up to 100 %.
- If you need more space, use **section G - Special instructions** (page 20).

Beneficiary for Insured 1	%	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
First name Last name			☐ Married ☐ Civil union spouse (Quebec only) ☐ Common-law spouse ☐ Other:	☐ F ☐ M	☐ Revocable ☐ Irrevocable
First name Last name			☐ Married ☐ Civil union spouse (Quebec only) ☐ Common-law spouse ☐ Other:	☐ F ☐ M	☐ Revocable ☐ Irrevocable
Beneficiary for Insured 2					
First name Last name			☐ Married ☐ Civil union spouse (Quebec only) ☐ Common-law spouse ☐ Other:	☐ F ☐ M	☐ Revocable ☐ Irrevocable
First name Last name			☐ Married ☐ Civil union spouse (Quebec only) ☐ Common-law spouse ☐ Other:	☐ F ☐ M	☐ Revocable ☐ Irrevocable

B - Beneficiary information (cont.)

B4 - Health Priorities - Business

Instructions : If the beneficiary of the **critical illness benefit** and **death benefit** is a corporation, you do not need to indicate the relationship between this beneficiary and the policyowner/insured. **However,** if the beneficiary is an individual, please indicate the relationship between this beneficiary and the second policyowner (individual) if the contract was issued in Quebec. If the contract was issued outside Quebec, please indicate the relationship between this beneficiary and the insured.

- The insured's beneficiary percentages must add up to 100 %.
- If you need more space, use **section G - Special instructions** (page 20).

Critical illness benefit		
Beneficiary	**%**	**Status**
Name		☐ Revocable ☐ Irrevocable
Name		☐ Revocable ☐ Irrevocable

Death benefit		
Beneficiary	**%**	**Status**
Name		☐ Revocable ☐ Irrevocable
Name		☐ Revocable ☐ Irrevocable

Health benefit

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**
First name Last name			☐ Married ☐ Self ☐ Civil union spouse (Quebec only) ☐ Common-law spouse ☐ Other :	☐ F ☐ M	☐ Revocable ☐ Irrevocable
First name Last name			☐ Married ☐ Self ☐ Civil union spouse (Quebec only) ☐ Common-law spouse ☐ Other :	☐ F ☐ M	☐ Revocable ☐ Irrevocable

B5 - Designation of a trustee for a minor beneficiary (provinces other than Quebec)

- To be completed for contracts issued outside Quebec only.
- If a minor beneficiary is named in **sections B1 - Death** (page 4) and **B3 - Critical illness** (page 5), a trustee may be named for that beneficiary.

Beneficiary for Insured 1	**Trustee**	**Trustee's date of birth (yyyy/mm/dd)**	**Relationship between the trustee and the beneficiary**	**Sex**
First name Last name	First name Last name			☐ F ☐ M
First name Last name	First name Last name			☐ F ☐ M
Beneficiary for Insured 2				
First name Last name	First name Last name			☐ F ☐ M
First name Last name	First name Last name			☐ F ☐ M

Desjardins Insurance
Life • Health• Retirement

C - Type and amount of insurance applied for

- Illustration (Head Office copy and underwriting requirements) must be submitted with the insurance application.
- For universal and participating life coverages, the "Illustration Acknowledgement and Signatures" must also be signed by the policyowner and submitted with the application.
- For SOLO disability coverages, please indicate the waiting period and the benefit period.

Insured 1		Insured 2	
Product	**Insurance Amount**	**Product**	**Insurance Amount**
	$		$
	$		$
	$		$
	$		$
	$		$
	$		$
Additional coverages:		**Additional coverages:**	

☐ Individual ☐ Joint first-to-die ☐ Joint last-to-die ☐ Joint last-to-die, paid-up first death

Speciality group

The distribution of the accumulated fund value (universal life) will be 100 % on payment of death benefit (default option).

Other options: ☐ 100 % upon first death ☐ Variable upon each death, specify:

Dividend option selection (Participating Whole Life coverage only)

☐ Enhanced insurance – lifetime guarantee ☐ Paid-up additions ☐ Annual premium reduction
☐ Enhanced insurance – 10-year guarantee ☐ Dividends on deposit ☐ Cash payment

D - Request for change

- Any change below requires completion of **part 2, section F - Evidence of insurability** (page 11) and any applicable sections in **parts 1 and 3.** (If you're adding one or more insureds, see the quick reference available on *web*.)
- For any request for change without evidence of insurability, please use form **09219E.**
- Contracts will be grandfathered when change requests are received. In some cases, a new contract will have to be issued.

Possible changes

Check the appropriate box for all products except SOLO disability coverages.

☐ Add coverages ☐ Change from regular to preferred rates ☐ Partial replacement
☐ Add insured(s) - Quick reference available on *web* ☐ Review an exclusion or extra premium ☐ Replacement within same contract
☐ Other:

Description of the changes requested for Insured 1	Amount of insurance From	To

Description of the changes requested for Insured 2	Amount of insurance From	To

Check the appropriate box for changes to SOLO disability coverages only.

☐ Add rider ☐ Occupation class change
☐ Benefit period increase ☐ Occupation class upgrade
☐ Change from regular to preferred rates ☐ Review an exclusion or extra premium
☐ Change premium structure from T65 to T10 ☐ Waiting period reduction
☐ Monthly income benefit increase ☐ Other: _____

E - Eligibility

E1 - Eligibility for SOLO disability coverages

ⓘ A proposed insured can apply for SOLO Disability Income and/or SOLO Loan Insurance in this section. If more than one proposed insured is applying for SOLO Disability Income and/or SOLO Loan Insurance, a separate application must be completed for each person.

- For SOLO Disability Income, please complete **questions 1 to 25.**
- For SOLO Loan Insurance, please complete **questions 1 to 18.** If you are asking for an occupation class upgrade, also complete **question 19.**
- For SOLO Healthcare, complete **section E2** (page 10) only.

Person who will be the SOLO Loan Insurance policyowner: ☐ **Policyowner 1** identified in **section A1** ☐ **Policyowner 2** identified in **section A1**
☐ Policyowner identified in **section A2** (Individual) ☐ Policyowner identified in **section A2** (Corporation, trust or other entity)

Specific situation

1- a) If you are a female, are you pregnant? ☐ Yes ☐ No
If **yes,** specify your due date (yyyy/mm/dd): _____

b) Are you on precautionary cessation of work? ☐ Yes ☐ No
If **yes,** you are only eligible for SOLO Loan Insurance.
Complete **section E1** based on your employment situation before your precautionary cessation of work.

2- Are you on parental leave? ☐ Yes ☐ No
If **yes,** you are only eligible for SOLO Loan Insurance.
Complete **section E1** based on your employment situation before your parental leave.

3- Are you eligible to receive benefits from:
a) Employment Insurance (EI)? ☐ Yes ☐ No
b) Workers' Compensation Plan - CNESST (formerly the CSST) / WCB / WSIB / WHSCC? ☐ Yes ☐ No

Employment profile

4- Profession or occupation

5- Professional designation/diploma obtained (level of education)

6- Date you began working in your current occupation (yyyy/mm/dd):
If less than 3 years, indicate previous occupation:

7- **Responsibilities and duties** - Indicate the percentage of your time spent on each type of responsibility and **list the specific activities** involved in the "Duties" column.

Responsibilities	Percentage %	Duties
a) Manual/physical		
b) Management/office work		
c) Sales		
d) Supervision		
e) Others, specify:		
TOTAL:	100 %	
f) Indicate the percentage of time spent travelling outside North America	%	

8- Number of hours worked per week: _____

9- Number of hours worked per week in the **last 4 weeks:** _____

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

11- Do you work from home? ☐ Yes ☐ No
If **yes,** answer the following questions:
a) Indicate the percentage of work you do from home in a year: _____ %
b) If you have regular clients, do they go to your home each week to receive your services? ☐ Yes ☐ No
c) **After deducting employment expenses,** did you earn an annual income of at least $50,000 in each of the last 2 years? ☐ Yes ☐ No

12- Do you have any other part-time or full-time work?
☐ Yes ☐ No
If **yes,** indicate:
a) Exact nature of your responsibilities: _____
_____
b) Number of hours worked per week: _____
c) Your annual income: $_____

13- Are you planning to change your occupation in the next **6 months?** ☐ Yes ☐ No
If **yes,** indicate the reason:

E - Eligibility (cont.)

E1 - Eligibility for SOLO disability coverages (cont.)

Company/employer profile

14- Name of company	15- Nature of business		
16- Address (No., street, apt.)	City	Province	Postal code
17- Company website			

18- a) Since when have you worked for this employer or been self-employed (yyyy/mm/dd)? _____

b) Please indicate your current employment situation:

☐ Employee

☐ Self-employed worker

☐ Business owner

c) If you are a self-employed worker or a business owner, please complete the table below:

Number of partners or shareholders:		Number of full-time employees (excluding owners):
Percentage of shares held in the company:	%	Number of part-time employees (excluding owners):

Insurable net annual earned income profile (earned income after overhead expenses but before taxes)

19- Earned income based on your current employment situation

a) ☐ Employee

Earned income is the amount reported on T1 Federal Tax Return: line 10100 plus line 10400, minus line 22900.

Annual income	Annual income (last year)	Annual income (prior to last year)
$	$	$

b) ☐ Self-employed worker paid on commission

c) ☐ Self-employed worker

d) ☐ Partners

Earned income is the net income reported on your T1 Federal Tax Return: lines 13500 to 14300 - the income to date is the income for the current fiscal year.

Income to date (current year)	Total income (last year)	Total income (prior to last year)
$	$	$

e) ☐ Owner of a business corporation/corporation (Inc.)

Earned income is the amount reported on your T1 Federal Tax Return: line 10100 plus line 10400, plus your share of the profits or losses. This income excludes pension income, interest, **dividends** from any source and any other investment income, rental income, capital gains, royalties, licence fees and support payments, and any deferred compensation and any other income that is not directly received in exchange for services rendered.

	Last year	Prior to last year
Salary	$	$
Corporation's profit (or loss)	$	$
Total	$	$

Fiscal year-end (yyyy/mm/dd):

f) ☐ Recognized agricultural producer:

Earned income includes amortization expenses.

Annual income	Annual income (last year)	Annual income (prior to last year)
$	$	$

SOLO DISABILITY

E - Eligibility (cont.)

E1 - Eligibility for SOLO disability coverages (cont.)

20- If you are self-employed, do you split your income for tax purposes? ☐ Yes ☐ No
If **yes,** what is the income splitting amount? $ _____

21- Calculate your unearned income from last year and estimate your unearned income for this year.
Does one of these amounts exceed the lesser of the following: $30,000 or 15% of the income you reported in **question 19?** ☐ Yes ☐ No
(Unearned income is income from sources other than your employment and is income that you would still receive even if you were disabled. Example: investment income, rental or copyrights, etc.)
If **yes,** complete **question 24** - Unearned income sources.

22- Does your net worth (assets minus liabilities) exceed $4,000,000? ☐ Yes ☐ No
If **yes,** complete **question 25** - Net worth.

23- Are you applying for the guaranteed benefit? ☐ Yes ☐ No
If **yes,** financial proof is required to determine eligibility. Please refer to the Representative guide.

24- Unearned income sources (Unearned income sources are excluded from the insurable net earned income declared in **question 19.**)

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

25- Net worth

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

E2 - Eligibility for SOLO Healthcare

Is the proposed insured:	**Insured 1**	**Insured 2**
a) covered by the provincial health insurance plan?	☐ Yes ☐ No	☐ Yes ☐ No
b) covered by the provincial drug insurance plan? If **no,** specify the reason:	☐ Yes ☐ No	☐ Yes ☐ No
c) a pregnant woman? If **yes,** specify the due date (yyyy/mm/dd): _____	☐ Yes ☐ No	☐ Yes ☐ No

Desjardins Insurance
Life • Health• Retirement

F - Evidence of insurability

F1 - Identification of proposed insureds

- If there are more than 2 proposed insureds, use another application form for them.

Insured 1			Insured 2		
First name			First name		
Last name at birth			Last name at birth		
Sex ☐ Female ☐ Male	Date of birth (yyyy/mm/dd)		Sex ☐ Female ☐ Male	Date of birth (yyyy/mm/dd)	
Height cm / in	Weight kg / lbs	Weight 1 year ago kg / lbs	Height cm / in	Weight kg / lbs	Weight 1 year ago kg / lbs
Cause of any weight change of 4.5 kg (10 lbs) or more in the last year:			Cause of any weight change of 4.5 kg (10 lbs) or more in the last year:		

F2 - Insurance in force

⚠ If this section is not completed, the application process can be delayed.

Individual life and critical illness coverages	Insured 1	Insured 2
Does the proposed insured currently have life or critical illness insurance (not including any group insurance coverage)? If **yes,** please complete the table below for each individual insurance coverage held with Desjardins Insurance or another company. (Do not include the coverages applied for in this application.)	☐ Yes ☐ No	☐ Yes ☐ No

Insured 1	Amount $	Name of company	Purpose of insurance	
			Personal	Business
LIFE			☐	☐
			☐	☐
CI			☐	☐
			☐	☐

Insured 2	Amount $	Name of company	Purpose of insurance	
			Personal	Business
LIFE			☐	☐
			☐	☐
CI			☐	☐
			☐	☐

SOLO disability coverages (including SOLO Disability Income and SOLO Loan Insurance) ☐ **Insured 1** or ☐ **Insured 2**

Does the proposed insured currently have disability insurance (including any group insurance coverage offered through an employer)? ☐ Yes ☐ No

If **yes,** please complete the table below for each disability insurance coverage held with Desjardins Insurance or another company. (Do not include the coverages applied for in this application.)

If the proposed insured is covered by the MÉDIC Construction insurance plan, please enter the plan letter here: _____

Disability insurance in force	Contract issue date (yyyy/mm/dd)	Monthly benefit	Waiting period	Benefit period	Taxable
Name of insurer					
Type of coverage ☐ Individual ☐ Group ☐ Loan - Business ☐ Overhead expenses ☐ Loan - Individual					☐ Yes ☐ No
Name of insurer					
Type of coverage ☐ Individual ☐ Group ☐ Loan - Business ☐ Overhead expenses ☐ Loan - Individual					☐ Yes ☐ No
Name of insurer					
Type of coverage ☐ Individual ☐ Group ☐ Loan - Business ☐ Overhead expenses ☐ Loan - Individual					☐ Yes ☐ No

F - Evidence of insurability (cont.)

F3 - Identification of the personal physician

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

Insured 1			**Insured 2** ☐ Same as for Insured 1		
Name of personal physician			Name of personal physician		
Address (No., street, apt.)			Address (No., street, apt.)		
City	Province	Postal code	City	Province	Postal code
10-digit phone number	Date of last visit (yyyy/mm/dd)		10-digit phone number	Date of last visit (yyyy/mm/dd)	
Reason for last visit and results			Reason for last visit and results		

F4 - Examinations ordered by the representative

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

⚠ Paramedical firm

☐ Dynacare Insurance Solutions ☐ ExamOne ☐ Other:

⚠ Inspection firm

☐ Dynacare Insurance Solution (Keyfacts) ☐ Other:

	Paramedical exam	Blood profile	Resting ECG	Stress ECG	Urine test	MVR	Inspection report	Others
Insured 1	☐	☐	☐	☐	☐	☐	☐	☐
Insured 2	☐	☐	☐	☐	☐	☐	☐	☐

Authorization number for Insured 1 (mandatory): _____

Authorization number for Insured 2 (mandatory): _____

Desjardins Insurance
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F - Evidence of insurability (cont.)

F5 - Mandatory questions for all proposed insureds

	Insured 1	Insured 2
1- Has the proposed insured submitted this application to replace a life, disability, critical illness or long term care insurance coverage issued by Desjardins Insurance or by another insurer? If **yes,** complete notice or prior notice of replacement.	☐ Yes ☐ No	☐ Yes ☐ No

- The following contract(s) will be cancelled if this application is approved: | | | |

	Insured 1	Insured 2
2- Has the proposed insured submitted one or more life, disability or critical illness insurance applications that are currently under review with Desjardins Insurance or other companies? If **yes,** complete the table below.	☐ Yes ☐ No	☐ Yes ☐ No

Type of coverage	Insured 1			Insured 2		
	Amount applied for $	Name of company	Total of amounts applied for by type of coverage (Include the amount applied for in this application)	Amount applied for $	Name of company	Total of amounts applied for by type of coverage (Include the amount applied for in this application)
Life						
Disability						
Critical illness						

	Insured 1	Insured 2
3- In the past **10 years,** has Desjardins Insurance or another company declined an application for life, disability or critical illness insurance for the proposed insured? If **yes,** complete the table below.	☐ Yes ☐ No	☐ Yes ☐ No

	Coverage applied for	Year	Reason for refusal
Insured 1	☐ Life ☐ Disability ☐ Critical illness		
Insured 2	☐ Life ☐ Disability ☐ Critical illness		

	Insured 1	Insured 2
4- Has the proposed insured used any form of tobacco or nicotine products (cigarette, cigarillo, cigar, pipe, electronic cigarette, nicotine gum or patches) or anti-smoking medication in the **past 12 months?** If **yes** and if the proposed insured is age **17 or over,** complete the table below.	☐ Yes ☐ No	☐ Yes ☐ No

	Type (if cigars, specify type)	Quantity	Frequency of use
Insured 1			☐ Daily ☐ Monthly ☐ Yearly
Insured 2			☐ Daily ☐ Monthly ☐ Yearly

	Insured 1	Insured 2
5- Is the proposed insured a former smoker? If **yes** and if the proposed insured is age **17 or over,** complete the table below.	☐ Yes ☐ No	☐ Yes ☐ No

	Date stopped (yyyy/mm/dd)	Past daily use
Insured 1		
Insured 2		

	Insured 1	Insured 2
6- Has the proposed insured declared bankruptcy within the **past 5 years?** If yes and if the proposed insured is age **18 or over,** complete the table below.	☐ Yes ☐ No	☐ Yes ☐ No

	Date of bankruptcy (yyyy/mm/dd)	Personal	Business	Date of discharge (yyyy/mm/dd)
Insured 1		☐	☐	
Insured 2		☐	☐	

F - Evidence of insurability (cont.)

If a paramedical exam from Desjardins Insurance is required for a proposed insured, you do not have to complete **section F6** for the proposed insured. However, if you choose to answer these questions, communication of decisions by the underwriter with the representative will be easier.

F6 - Supplementary questions

	Insured 1	Insured 2
7- a) Has the proposed insured participated in activities such as flying, skydiving, scuba diving, mountaineering, climbing, off-trail skiing (including heli skiing), motor vehicle racing (including boat racing) or any other hazardous sports over the **past 2 years ?** If **yes,** complete the appropriate questionnaire(s) available on *web*.	☐ Yes ☐ No	☐ Yes ☐ No
b) Is the proposed insured planning to participate in any hazardous sports over the **next 12 months ?** If **yes,** complete the appropriate questionnaire(s) available on *web*.	☐ Yes ☐ No	☐ Yes ☐ No
8- Has the proposed insured been found guilty or accused of a Criminal Code offence within the **past 5 years,** including for driving under the influence of alcohol or drugs ? (Answer **yes** if the proposed insured is currently facing charges for a criminal offence or if they are awaiting trial.) If **yes,** complete the table below.	☐ Yes ☐ No	☐ Yes ☐ No

	Date of offence (yyyy/mm)	Type of offence	Date of offence (yyyy/mm)	Type of offence	Driver's licence reinstated (yyyy/mm)
Insured 1					
Insured 2					

	Insured 1	Insured 2
9- Has the proposed insured been found guilty of any traffic offences or a driving infraction that led to the suspension or loss of their driver's licence within the **past 5 years ?** If **yes,** complete the table below.	☐ Yes ☐ No	☐ Yes ☐ No

	Date of offence (yyyy/mm)	Type of offence	Km over limit	Date of offence (yyyy/mm)	Type of offence	Km over limit	Driver's licence reinstated (yyyy/mm)
Insured 1							
Insured 2							

	Insured 1	Insured 2
10- a) Has the proposed insured travelled or stayed outside Canada or the United States in the **past 12 months ?**	☐ Yes ☐ No	☐ Yes ☐ No
b) Does the proposed insured intend to do so in the **next 12 months ?**	☐ Yes ☐ No	☐ Yes ☐ No
If **yes,** complete the table below or complete the foreign residence/travel questionnaire available on *web*.		

	Country	City	Date of departure (yyyy/mm/dd)	Date of return (yyyy/mm/dd)	Purpose of trip
Insured 1					
Insured 2					

	Insured 1	Insured 2
11- Has the proposed insured applied for or received disability benefits following an illness or an accident ? If **yes,** complete the table below.	☐ Yes ☐ No	☐ Yes ☐ No

	Name of company	Date of onset of disability (yyyy/mm/dd)	Cause of disability	Duration of disability
Insured 1				
Insured 2				

F - Evidence of insurability (cont.)

F6 - Supplementary questions (cont.)

	Insured 1	Insured 2
12- **Family history** Has the proposed insured reported a history of cancer, heart disease, stroke, high cholesterol, high blood pressure, diabetes, kidney disorders, multiple sclerosis, Huntington's chorea, colon polyps, motor neuron disorder, muscular dystrophy, Parkinson's disease, Alzheimer's disease, cystic fibrosis or any other hereditary disease in his family (father, mother, brothers, sisters)? If **yes,** complete the table below. For all cases of cancer, indicate its location in **section F9 - Explanations** (page 19).	☐ Yes ☐ No	☐ Yes ☐ No

Insured 1	Illness(es)	Age at onset of illness	Age if living	Age at death	Cause of death
Father					
Mother					
Brothers					
Sisters					

Insured 2	Illness(es)	Age at onset of illness	Age if living	Age at death	Cause of death
Father					
Mother					
Brothers					
Sisters					

13- Has the proposed insured ever consulted a healthcare professional, received treatment or undergone surgery or tests involving any of the following? If **yes,** complete the table below and provide relevant details in **section F9 - Explanations** (page 19).	☐ Yes ☐ No	☐ Yes ☐ No

	Insured 1	Insured 2		Insured 1	Insured 2
Abnormality of the immune system, including AIDS and positive HIV test	☐	☐	Heart	☐	☐
Alcoholism	☐	☐	Hepatitis	☐	☐
Alzheimer's	☐	☐	High blood pressure	☐	☐
Attention deficit disorder and/or hyperactivity	☐	☐	Hypertriglyceridemia	☐	☐
Backaches	☐	☐	Hypercholesterolemia (high cholesterol)	☐	☐
Blood disorders	☐	☐	Kidney or bladder	☐	☐
Blood vessels	☐	☐	Liver	☐	☐
Brain or neurological disorders	☐	☐	Motor neuron disorder	☐	☐
Breasts	☐	☐	Multiple sclerosis	☐	☐
Burnout	☐	☐	Muscles	☐	☐
Cancer or tumour	☐	☐	Muscular dystrophy	☐	☐
Depression, anxiety, adjustment disorder or other psychological disorder	☐	☐	Musculoskeletal disorders	☐	☐
Diabetes	☐	☐	Optic neuritis	☐	☐
Drug addiction	☐	☐	Parkinson's disease	☐	☐
Ears (including deafness and excluding otitis)	☐	☐	Prostate	☐	☐
Epilepsy, convulsions, dizziness or loss of consciousness	☐	☐	Pulmonary disorders (including sleep apnea)	☐	☐
Eyes (including blindness and excluding myopia and presbyopia)	☐	☐	Sexually transmitted diseases	☐	☐
Gastro-intestinal system	☐	☐	Stroke, transient ischemic attack (TIA), cerebrovascular accident (CVA)	☐	☐
Any other illness not mentioned above:				☐	☐

F - Evidence of insurability (cont.)

F6 - Supplementary questions (cont.)

	Insured 1	Insured 2
14- Excluding the answers in **question 13,** has the proposed insured ever:		
a) consulted a physician, chiropractor, physiotherapist, psychologist or other healthcare professional for a physical or mental disorder not already mentioned or are they taking medication? If **yes,** please provide more details and the dosage for any medications, if applicable, in section **F9 – Explanations** (page 19).	☐ Yes ☐ No	☐ Yes ☐ No
b) had an electrocardiogram, an X-ray, a mammography, an electromyography, a scan, an MRI, blood tests or other diagnostic tests, been hospitalized or undergone surgery? If **yes,** please provide more details in section **F9 – Explanations** (page 19).	☐ Yes ☐ No	☐ Yes ☐ No
15- Has the proposed insured ever suffered from, or do they currently have, health-related symptoms, discomforts or signs for which they have not yet consulted a physician, or have they been advised to undergo tests or surgery that have yet to be completed or for which they are currently awaiting the results? If **yes,** please provide more details in section **F9 – Explanations** (page 19).	☐ Yes ☐ No	☐ Yes ☐ No
16- Has the proposed insured undergone or been advised to undergo laboratory tests to detect the presence of the AIDS virus or antibodies to the AIDS virus in the **past 5 years?** If **yes,** please provide more details in section **F9 – Explanations** (page 19).	☐ Yes ☐ No	☐ Yes ☐ No
17- Has the proposed insured ever used, or do they currently use drugs or narcotics without a medical prescription? If **yes,** complete the drug use questionnaire available on web.	☐ Yes ☐ No	☐ Yes ☐ No
18- a) Has the proposed insured ever consumed, or do they currently consume alcoholic beverages? If **yes,** complete the table below specifying the current weekly consumption and consumption of the **last 3 years** if different.	☐ Yes ☐ No	☐ Yes ☐ No

	Current weekly consumption	Weekly consumption during the last 3 years
Insured 1		
Insured 2		

b) Has the proposed insured undergone or been advised to undergo treatment for alcoholism, been a member of a support group such as Alcoholics Anonymous, or been advised to reduce their alcohol consumption? If **yes,** complete the questionnaire related to alcohol consumption available on web.	☐ Yes ☐ No	☐ Yes ☐ No
19- Has the proposed insured suffered from pain in the cervical, dorsal or lumbar spine or been treated for such pain within the **past 5 years?** If **yes,** complete the back pain or spine impairment questionnaire available on web.	☐ Yes ☐ No	☐ Yes ☐ No

20- **Questions to be answered for SOLO Healthcare only:**	Insured		Child			
Has the proposed insured:	1	2	1	2	3	4
a) used any medication for 20 consecutive days or more within the **past 2 years?**	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
b) taken or been advised to use a medication or treatment for a chronic or recurring medical condition or does the proposed insured expect to use any medication or treatment within the **next 3 months?**	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

If **yes,** provide details below:

Note: Medications used for birth control or to treat minor ailments like cold or flu are not to be considered when answering this question.

Name of the proposed insured	Name of the drug, medication or treatment	Condition being treated	Strength and daily dosage of the drug or medication	Monthly Cost	Length of time on this drug, medication or treatment

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F - Evidence of insurability (cont.)

F7 - Additional questions - Critical illness coverage for any child under age 16

- Complete this section ONLY if the proposed insured identified in **section A1** is a child **under age 16** and critical illness coverage is applied for.

General questions	Insured 1	Insured 2
If the proposed insured <u>does not have any siblings</u>, go to question 24.		
21- How many siblings are there in the proposed insured's family?		
22- Do **all** of the proposed insured's siblings currently have critical illness insurance? If **no,** please explain why:	☐ Yes ☐ No	☐ Yes ☐ No
23- If **all** of the proposed insured's siblings currently have critical illness insurance, are they all insured for the same amount? If **no,** please explain why:	☐ Yes ☐ No	☐ Yes ☐ No
24- Does the proposed insured's mother and/or father currently have critical illness insurance?	☐ Yes ☐ No	☐ Yes ☐ No
If **yes,** indicate the insurance amount for each parent with critical illness insurance: **Mother**	$	$
If **no,** please explain why: **Father**	$	$

Medical history	Insured 1	Insured 2
25- Does the proposed insured have, or have they been diagnosed with, or been told they have, symptoms associated with any of the following?		
a) Physical handicap	☐ Yes ☐ No	☐ Yes ☐ No
b) Amyotrophic lateral sclerosis	☐ Yes ☐ No	☐ Yes ☐ No
c) Cystic fibrosis	☐ Yes ☐ No	☐ Yes ☐ No
d) Neurological impairment including autism, cerebral palsy, hyperactivity, attention deficit disorder, developmental delay, Rett's syndrome	☐ Yes ☐ No	☐ Yes ☐ No
If **yes,** please provide details for each health condition in **Section F9 - Explanations.**		
26- If the proposed insured is currently under age 1, was the term of their mother's pregnancy **less than 36 weeks?** If **yes,** please explain why:	☐ Yes ☐ No	☐ Yes ☐ No

F - Evidence of insurability (cont.)

F8 - Questionnaire regarding children to be insured

- To be completed **ONLY** if children are to be insured under the Children's Life Protection coverage or SOLO Healthcare.

Child 1						Child 2					
First name						First name					
Last name at birth						Last name at birth					
Sex ☐ Female ☐ Male		Date of birth (yyyy/mm/dd)				Sex ☐ Female ☐ Male		Date of birth (yyyy/mm/dd)			
Height cm	in	Weight kg	lbs	Weight 1 year ago kg	lbs	Height cm	in	Weight kg	lbs	Weight 1 year ago kg	lbs
Cause of any weight change of 4.5 kg (10 lbs) or more in the last year:						Cause of any weight change of 4.5 kg (10 lbs) or more in the last year:					

Child 3						Child 4					
First name						First name					
Last name at birth						Last name at birth					
Sex ☐ Female ☐ Male		Date of birth (yyyy/mm/dd)				Sex ☐ Female ☐ Male		Date of birth (yyyy/mm/dd)			
Height cm	in	Weight kg	lbs	Weight 1 year ago kg	lbs	Height cm	in	Weight kg	lbs	Weight 1 year ago kg	lbs
Cause of any weight change of 4.5 kg (10 lbs) or more in the last year:						Cause of any weight change of 4.5 kg (10 lbs) or more in the last year:					

Previous applications for insurance for the children

27- In the **past 10 years,** has Desjardins Insurance or another company declined an application for life, healthcare or critical illness insurance for the child to be insured?

If **yes** for any of the children to be insured, complete the table below.

☐ Yes ☐ No

	Coverage applied for	Year	Reason for refusal
Child 1	☐ Life ☐ Healthcare ☐ Critical illness		
Child 2	☐ Life ☐ Healthcare ☐ Critical illness		
Child 3	☐ Life ☐ Healthcare ☐ Critical illness		
Child 4	☐ Life ☐ Healthcare ☐ Critical illness		

F - Evidence of insurability (cont.)

Medical questions for the children to be insured

28- Have any of the children to be insured ever consulted a healthcare professional, received treatment or undergone surgery or tests involving any of the following?

If **yes,** complete the table below for each applicable child and provide details in section **F9 – Explanations.**

☐ Yes ☐ No

	Child					Child			
	1	2	3	4		1	2	3	4
Abnormality of the immune system, including AIDS and positive HIV test	☐	☐	☐	☐	Heart	☐	☐	☐	☐
Alcoholism	☐	☐	☐	☐	Hepatitis	☐	☐	☐	☐
Attention deficit disorder and/or hyperactivity	☐	☐	☐	☐	High blood pressure	☐	☐	☐	☐
Backaches	☐	☐	☐	☐	Hypertriglycerides	☐	☐	☐	☐
Blood disorders	☐	☐	☐	☐	Hypercholesterolemia (high cholesterol)	☐	☐	☐	☐
Blood vessels	☐	☐	☐	☐	Kidney or bladder	☐	☐	☐	☐
Brain or neurological disorders	☐	☐	☐	☐	Liver	☐	☐	☐	☐
Breasts	☐	☐	☐	☐	Motor neuron disorder	☐	☐	☐	☐
Burnout	☐	☐	☐	☐	Multiple sclerosis	☐	☐	☐	☐
Cancer or tumour	☐	☐	☐	☐	Muscles	☐	☐	☐	☐
Depression, anxiety, adjustment disorder or other psychological disorder	☐	☐	☐	☐	Muscular dystrophy	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	Musculoskeletal disorders	☐	☐	☐	☐
Drug addiction	☐	☐	☐	☐	Optic neuritis	☐	☐	☐	☐
Ears (including deafness and excluding otitis)	☐	☐	☐	☐	Pulmonary disorders (including asthma and sleep apnea)	☐	☐	☐	☐
Epilepsy, convulsions, dizziness or loss of consciousness	☐	☐	☐	☐	Sexually transmitted diseases	☐	☐	☐	☐
Eyes (including blindness and excluding myopia and presbyopia)	☐	☐	☐	☐	Stroke, transient ischemic attack (TIA), cerebrovascular accident (CVA)	☐	☐	☐	☐
Gastro-intestinal system	☐	☐	☐	☐	Any other illness not mentioned above:	☐	☐	☐	☐

F9 - Explanations

No.	Name of proposed insured or child to be insured	Illness, diagnosis, surgery, consultation, treatment, medication, dosage, results, date of last epileptic seizure or asthma attack or other important information	Date (yyyy/mm)	Duration	Name and address of physicians, including specialty and hospital (specify if treated in hospital, outpatient clinic or physician's office)

G - Special instructions

• Provide additional details relevant to contract issue, premium payment or request for change.

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H - Payment and premium instructions

H1 - Premium mode and method

Mode	☐ Annual $ _____	☐ Semi-annual $ _____	☐ Monthly $ _____
Method	☐ Automatic withdrawal (PAD) - **Please complete section H2.**		
	☐ Cheque (direct billing - not available with monthly premium)		

		Required for temporary/conditional insurance agreement		
Initial premium	☐ On delivery (COD)	☐ Cheque included with this application	☐ Automatic withdrawal (PAD) - **Please complete section H2.**	
	☐ Use of cash values from contract number(s)	No.:	No.:	No.:

H2 - Pre-authorized debit agreement (PAD) ☐ To be provided on delivery

Complete this section when "Automatic withdrawal (PAD)" is selected as the method of payment. **To be valid, account holder(s) must sign the "Pre-authorized debit agreement (PAD)" portion of section Q on page 33.**

⚠ **IMPORTANT: Attach a personal cheque marked "VOID" to avoid errors in transcription. Only a valid chequing account can be used (not a line of credit account).**

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

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) from my account (pre-authorized debit or PAD) according to my instructions, at the frequency indicated:

☐ Monthly ☐ Semi-annual ☐ Annual

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

***For a universal life contract, the draw date will be the issue date of the contract.**

Contract number(s)	**Amount to be withdrawn**
	Total

Special instructions (You can use this section to apply for a Premium Deposit Account.)

Type of PAD Agreement: ☐ Personal/individual ☐ Business

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.payments.ca.

The cancellation of this PAD Agreement does not terminate the policyowner's obligations under their 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.payments.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.

Desjardins Insurance refers to Desjardins Financial Security Life Assurance Company.

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I - Temporary insurance agreement in case of death (to be completed if applying for life insurance)

The proposed insured being between 31 days and age 65, inclusively, could be eligible for coverage under the Temporary insurance agreement in case of death.

Eligibility questions	Insured 1	Insured 2
1- During the **last 60 months,** has the proposed insured consulted a physician or another health professional for a heart attack, angina, stroke, cancer, AIDS or any other infection from HIV, diagnosed or suspected, or is the proposed insured waiting for results or a diagnosis following a consultation?	☐ Yes ☐ No	☐ Yes ☐ No
2- Has the proposed insured ever submitted a life insurance application that was rated, declined or postponed by Desjardins Insurance or any other insurer?	☐ Yes ☐ No	☐ Yes ☐ No

Any proposed insured who answers **no** to all of these questions is eligible for coverage under the Temporary insurance agreement in case of death.
The Temporary insurance agreement in case of death takes effect as soon as all conditions stipulated in the agreement are fulfilled. The representative will provide a copy of these conditions to the policyowner. Please complete and sign the Receipt for the initial premium - **section P** (page 29).

J - Temporary insurance agreement in case of critical illness (to be completed if applying for critical illness insurance)

The proposed insured being between 31 days and age 65, inclusively, could be eligible for coverage under the Temporary insurance agreement in case of critical illness.

Eligibility questions	Insured 1	Insured 2
1- Has the proposed insured ever been treated by or consulted a physician or had symptoms relating to heart or neurological problems, vascular problems, suspected heart attack, chest pain, diabetes, tumour or cancer, transient ischemic attack, stroke, any chronic kidney, liver or lung diseases, multiple sclerosis, paralysis, blindness, deafness, loss of speech, dismemberment, coma, major burns, AIDS or any other infection from HIV?	☐ Yes ☐ No	☐ Yes ☐ No
2- During the **last 2 years,** has the proposed insured consulted a physician or another health professional who recommended tests, any investigations or surgeries (for reasons other than a pregnancy or childbirth) that have not yet occurred or for which results have not been received, or has the proposed insured experienced any symptoms for which no consultation was pursued?	☐ Yes ☐ No	☐ Yes ☐ No
3- During the **last 90 days,** has the proposed insured been admitted to or advised to be admitted to a hospital or a clinic for any reasons other than a pregnancy or childbirth?	☐ Yes ☐ No	☐ Yes ☐ No
4- During the **last 2 years,** has any application for life insurance, health insurance, disability insurance, critical illness insurance or long term care insurance for the proposed insured been rated, declined or modified in any way?	☐ Yes ☐ No	☐ Yes ☐ No

Any proposed insured who answers **no** to all of these questions is eligible for coverage under the Temporary insurance agreement in case of critical illness.
The Temporary insurance agreement in case of critical illness takes effect as soon as all of the conditions stipulated in the agreement are fulfilled. The representative will provide a copy of these conditions to the policyowner. Please complete and sign the Receipt for the initial premium - **section P** (page 29).

K - Conditional insurance agreement in case of disability (to be completed if applying for disability insurance)

The proposed insured, being between age 18 and 60, inclusively, could be eligible for coverage under the Conditional insurance agreement in case of disability.

Eligibility questions	Insured 1	Insured 2
1- During the **last 2 years,** has the proposed insured ever been treated by or consulted a physician or had symptoms relating to heart or neurological problems, vascular problems, chest pain, diabetes, tumour or cancer, transient ischemic attack, stroke, any chronic kidney, liver or lung diseases, multiple sclerosis, paralysis, back or spine disorder, depression, burn-out, emotional, nervous or mental disorders, chronic fatigue syndrome, AIDS or any other infection from HIV?	☐ Yes ☐ No	☐ Yes ☐ No
2- During the **last 2 years,** has the proposed insured consulted a physician or another health professional who recommended tests, any investigations or surgeries (for reasons other than a pregnancy or childbirth) that have not yet occurred or for which results have not been received, or has the proposed insured experienced any symptoms for which no consultation was pursued?	☐ Yes ☐ No	☐ Yes ☐ No
3- During the **last 90 days,** has the proposed insured been admitted to or advised to be admitted to a hospital or a clinic for any reasons other than a pregnancy or childbirth?	☐ Yes ☐ No	☐ Yes ☐ No
4- During the **last 2 years,** has any application for life insurance, health insurance, disability insurance, critical illness insurance or long term care insurance for the proposed insured been rated, declined or modified in any way?	☐ Yes ☐ No	☐ Yes ☐ No
5- Is the proposed insured currently unable to perform any duties of his present occupation because of injury or sickness?	☐ Yes ☐ No	☐ Yes ☐ No

Any proposed insured who answers **no** to all of these questions is eligible for coverage under the Conditional insurance agreement in case of disability.
Instructions for the representative: No person is authorized to accept payment or issue the Conditional insurance agreement in case of disability if the proposed insured:
1- has answered **yes** to or did not answer one of the eligibility questions asked above; **or**
2- is under 18 or over 60.
The Conditional insurance agreement in case of disability takes effect as soon as all conditions stipulated in the agreement are fulfilled. The representative will provide a copy of these conditions to the policyowner. Please complete and sign the Receipt for the initial premium - **section P** (page 29).

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Temporary insurance agreement in case of death

Under this Temporary insurance agreement in case of death, the coverage providing for the payment of a benefit upon the death of the proposed insured takes effect on the date the insurance application is signed, subject to the following conditions:

1- the proposed insured is between 31 days and age 65, inclusively, on the date the application is signed;

2- the proposed insured answered **no** to all of the eligibility questions from **section I** (page 23) of the application;

3- **Initial premium payment:** on signing the application, the policyowner must pay at least one monthly premium or 1/20 of the premium for a single-premium policy, depending on the coverages applied for in this application. However, the policyowner is not required to pay any amount exceeding one monthly premium for coverage of $1,000,000. Desjardins Insurance sets a $1,000,000 limit under the Temporary insurance agreement in case of death, which cannot be invalidated even if the initial premium paid is higher than the minimum required. If payment of the initial premium is not honoured, this Temporary insurance agreement in case of death will be deemed to have never taken effect;

4- **Maximum death benefit:** the total death benefit available under all Temporary insurance agreements in case of death issued by Desjardins Insurance for the same person is the amount of insurance applied for on that insured person or a maximum of $1,000,000, whichever is less. If applicable, this death benefit will be reduced by any advance payment made to the policyowner subsequent to a critical illness claim;

5- **Policy internal replacement:** if the proposed insured dies before the new policy becomes effective, Desjardins Insurance agrees to pay the beneficiary the higher of the amount payable under the replaced policy or the amount payable under this Temporary insurance agreement in case of death.

If the conditions on both sides of this page apply, detach this section of the application and give it to the policyowner. Otherwise, leave this section attached to the application.

Temporary insurance agreement in case of critical illness

Under this Temporary insurance agreement in case of critical illness, the coverage providing for a critical illness benefit on the proposed insured's life takes effect on the date the insurance application is signed, subject to the following conditions:

1- the proposed insured is between 31 days and age 65, inclusively, on the date the application is signed;

2- the proposed insured answered **no** to all of the eligibility questions from **section J** (page 23) of the application;

3- **Initial premium payment:** on signing the application, the policyowner must pay at least one monthly premium or 1/20 of the premium for a single-premium policy, depending on the coverages applied for in this application. However, the policyowner is not required to pay any amount exceeding one monthly premium for coverage of $500,000. Desjardins Insurance sets a $500,000 limit under the Temporary insurance agreement in case of critical illness, which cannot be invalidated even if the initial premium paid is higher than the minimum required. If payment of the initial premium is not honoured, this Temporary insurance agreement in case of critical illness will be deemed to have never taken effect;

4- **Maximum critical illness benefit:** the total critical illness benefit available under all Temporary insurance agreements in case of critical illness issued by Desjardins Insurance for the same person is the amount of insurance applied for on that insured person or a maximum of $500,000, whichever is less.

LIST OF COVERED CONDITIONS: this Temporary insurance agreement in case of critical illness protects the proposed insured for the following covered conditions, if the diagnosis is made after the date the application is signed:

Blindness

Definite diagnosis of the total and irreversible loss of vision in both eyes, evidenced by the corrected visual acuity being 20/200 or less in both eyes, or the field of vision being less than 20 degrees in both eyes.

Coma

Definite diagnosis of a state of unconsciousness with no reaction to external stimuli or response to internal needs for a continuous period of at least 96 hours, and for which period the Glasgow coma score must be 4 or less. **Exclusion:** no benefit will be payable under this condition for a medically induced coma, a coma which results directly from alcohol or drug use, or a diagnosis of brain death.

Deafness

Definite diagnosis of the total and irreversible loss of hearing in both ears, with an auditory threshold of 90 decibels or greater within the speech threshold of 500 to 3,000 hertz.

Heart attack

Definite diagnosis of the death of heart muscle due to obstruction of blood flow, that results in rise and fall of biochemical cardiac markers to levels considered diagnostic of myocardial infarction, with at least one of the following: heart attack symptoms, new electrocardiogram (ECG) changes consistent with a heart attack, development of new Q waves during or immediately following an intra-arterial cardiac procedure including, but not limited to, coronary angiography and coronary angioplasty. **Exclusions:** no benefit will be payable under the definition of "heart attack" for: elevated biochemical cardiac markers as the result of an intra-arterial cardiac procedure, including but not limited to a coronary angiography and coronary angioplasty in the absence of new Q waves; ECG changes suggesting a prior myocardial infarction that does not meet the definition of "heart attack" as described above. Also, no benefit will be payable if the insured person dies within 30 days of a heart attack diagnosis.

Loss of limbs

Definite diagnosis of the complete severance of 2 or more limbs at or above the wrist or ankle joint as the result of an accident or medically required amputation.

If the conditions on both sides of this page apply, detach this section of the application and give it to the policyowner. Otherwise, leave this section attached to the application.

Conditional insurance agreement in case of disability

Under this Conditional insurance agreement in case of disability, the SOLO disability coverage submitted for the proposed insured takes effect on the effective date subject to the following conditions:

1- the proposed insured is between age of 18 and 60, inclusively, on the date the application is signed;

2- the proposed insured answered **no** to all of the eligibility questions from **section K** (page 23) of the application;

3- **Initial premium payment:** on signing the application, the policyowner must pay at least one monthly premium or 1/20 of the premium for a single-premium policy, depending on the coverages applied for in this application. However, the policyowner is not required to pay any amount exceeding one monthly premium for a monthly disability benefit of $5,000. Desjardins Insurance sets a limit of $5,000 for the monthly disability benefit under the Conditional insurance agreement in case of disability, which cannot be invalidated even if the initial premium paid is higher than the minimum required. If payment of the initial premium is not honoured, this Conditional insurance agreement in case of disability will be deemed to have never taken effect;

4- **Maximum benefit payable in case of disability:** this Conditional insurance agreement in case of disability provides for the same benefit payable as the SOLO disability coverage applied for, with the same amount of monthly disability benefit (maximum of $5,000 for all Conditional insurance agreements in case of disability issued by Desjardins Insurance for the same person), the same waiting period and benefit period, with the condition that, according to Desjardins Insurance's directives and underwriting procedures, the proposed insured be entitled to this coverage without any substandard premium, exclusion, limitation, reduction or other modifications. If such changes are necessary to issue the requested contract, the benefit payable under this Conditional insurance agreement in case of disability will be limited to the modified SOLO disability coverage offered to the proposed insured on the effective date of this agreement.

Definitions:

The **effective date** for this Conditional insurance agreement in case of disability is the later of the following dates:

1- the date the application is signed;

2- the date on which the requested paramedical, medical exams and any other tests have been completed, according to Desjardins Insurance's underwriting procedures.

The definition for **"disability"** is the one stated in the contract of the SOLO disability coverage applied for in this application.

If the conditions on both sides of this page apply, detach this section of the application and give it to the policyowner. Otherwise, leave this section attached to the application.

Temporary insurance agreement in case of death (cont.)

Exclusions: no benefit will be payable in the event of the insured person's death under this Temporary insurance agreement if:

1- the application is a group life insurance conversion;

2- the proposed insured commits suicide, whether sane or insane. Desjardins Insurance's liability is then limited to the refund of the initial premium;

3- the claim is for additional benefits provided for under an Accidental Death, Dismemberment or Loss of use coverage.

Statements: any statements made by the policyowner or the proposed insureds in this application for life insurance may be contested with respect to this Temporary insurance agreement in case of death.

Termination of coverage: coverage under this Temporary insurance agreement in case of death terminates on the earlier of the following dates:

1- the effective date of the policy applied for;

2- the issue date of a policy that differs from the policy applied for, such policy being made as a counter-offer by Desjardins Insurance to the policyowner;

3- the date on which Desjardins Insurance sends the policyowner a letter advising that coverage under this Temporary insurance agreement in case of death has terminated or that this application for life insurance has been rejected;

4- the 91st day following the date the application is signed.

No representative of Desjardins Insurance is authorized to amend this Temporary insurance agreement in case of death.

Temporary insurance agreement in case of critical illness (cont.)

Loss of speech

Definite diagnosis of the total and irreversible loss of the ability to speak as the result of physical injury or disease, for a period of at least 180 days. **Exclusion:** no benefit will be payable under this condition for all psychiatric related causes.

Paralysis

Definite diagnosis of the total loss of muscle function of 2 or more limbs as a result of injury or disease to the nerve supply of those limbs, for a period of at least 90 days following the precipitating event.

Severe burns

Definite diagnosis of third-degree burns over at least 20% of the body surface.

Stroke (cerebrovascular accident)

Definite diagnosis of an acute cerebrovascular event caused by intra-cranial thrombosis or haemorrhage, or embolism from an extra-cranial source, with acute onset of new neurological symptoms, and new objective neurological deficits on clinical examination persisting for more than 30 days following the date of diagnosis. These new symptoms and deficits must be corroborated by diagnostic imaging testing. **Exclusion:** no benefit will be payable under this condition for transient ischaemic attacks, intracerebral vascular events due to trauma, or lacunar infarcts which do not meet the definition of "stroke" as described above.

Exclusions: no benefit will be payable if:

1- the insured person suffers from any condition covered under this Temporary insurance agreement that results, directly or indirectly, from: self-inflicted injuries or a suicide attempt, whether the insured person is sane or insane; the insured person's participation in any criminal act or related act; war (whether war is declared or undeclared), riot or revolution, whether or not the insured person took part; 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; the illegal or illicit use of any drug; the voluntary absorption or use of any toxic substance or any type of gas; 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.

2- the condition covered under this Temporary insurance agreement is diagnosed after the insured person's death.

Statements: any statements made by the policyowner or the proposed insureds in this application for critical illness insurance may be contested with respect to this Temporary insurance agreement in case of critical illness.

Termination of coverage: coverage under this Temporary insurance agreement in case of critical illness terminates on the earlier of the following dates:

1- the effective date of the policy applied for;

2- the issue date of a policy that differs from the policy applied for, such policy being made as a counter-offer by Desjardins Insurance to the policyowner;

3- the date on which Desjardins Insurance sends the policyowner a letter advising that coverage under this Temporary insurance agreement in case of critical illness has terminated or that this application for critical illness insurance has been rejected;

4- the 91st day following the date the application is signed.

No representative of Desjardins Insurance is authorized to amend this Temporary insurance agreement in case of critical illness.

Conditional insurance agreement in case of disability (cont.)

Exclusions and limitations:

1- No benefit is payable under this Conditional insurance agreement in case of disability if there are important facts not being declared or if there is a fraudulent declaration in the application and/or within the requested medical exam, if applicable.

2- This Conditional insurance agreement in case of disability also considers all conditions, exclusions and limitations described in the SOLO disability coverage submitted for the proposed insured.

Declarations: any statements made by the policyowner or the proposed insured in this application for disability insurance may be contested with respect to this Conditional insurance agreement in case of disability.

Termination of coverage: coverage under this Conditional insurance agreement in case of disability terminates on the earlier of the following dates:

1- the effective date of the policy applied for;

2- the issue date of a policy that differs from the policy applied for, such policy being made as a counter-offer by Desjardins Insurance to the policyowner;

3- the date on which Desjardins Insurance sends the policyowner a letter advising that coverage under this Conditional insurance agreement in case of disability has terminated or that this application for disability insurance has been rejected;

4- the 91st day following the date the application is signed.

No representative of Desjardins Insurance is authorized to amend this Conditional insurance agreement in case of disability.

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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 healthcare professional or establishment, MIB, LLC, 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 identified in **section F3 - Identification of the personal physician** (page 12), 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, LLC, including information on my health.

This authorization also applies to collecting, using and disclosing personal and medical information concerning my minor children, insofar as they are subject to my application.

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

The following people have read this authorization before signing it:

- each proposed insured age **14 or older** (Quebec) or **16 or older** (provinces other than Quebec);
- each person authorized to sign on behalf of a proposed insured **under age 14** (Quebec) or **under age 16** (provinces other than Quebec).

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

X _____ X _____ _____
Signature of proposed insured 1 | Signature of proposed insured 2 | Date (yyyy/mm/dd)

Proposed insured **under age 14** (Quebec) or **under age 16** (provinces other than Quebec)

The signature of a parent, guardian or legal representative is required for this person.

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

_____ X _____ _____
First and last names of the person signing for proposed insured 1 (please print) | Signature | Date (yyyy/mm/dd)

_____ X _____ _____
First and last names of the person signing for proposed insured 2 (please print) | Signature | Date (yyyy/mm/dd)

M - Notice applicable to MIB, LLC - 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, LLC, 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, LLC member company, upon request, MIB, LLC will supply such company with the information it has on file about this person.

MIB, LLC 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, LLC 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, LLC is also bound by U.S. laws regarding the disclosure of personal information. To review MIB, LLC's Consumer Privacy Policy, please visit www.mib.com/privacy_policy.html.

Upon request, MIB, LLC will disclose all of the information in an insured's file to that insured. Insureds can contact MIB, LLC by emailing canadadisclosure@mib.com or calling 1-866-692-6901. Insureds who dispute the accuracy of the information MIB, LLC has on record for them can seek a correction in accordance with the procedures set forth on MIB, LLC's website at www.mib.com. They can also write to MIB, LLC's information office at 50 Braintree Hill Park, Suite 400, Braintree MA 02184-8734.

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, LLC at www.mib.com.

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N - 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.

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O - Authorization to disclose supplementary personal information to the representative

This authorization form is not required for an insurance application.
Note: For the purposes of this form, the term "representative" refers to the representative the policyowner does business with.

Proposed insured 1	Proposed insured 2
First and last names	First and last names
Date of birth (yyyy/mm/dd)	Date of birth (yyyy/mm/dd)

1- By signing this authorization form, I authorize Desjardins Insurance to provide my representative and their financial centre administrative staff with supplementary personal information about me that is outside the scope of what is normally provided as part of an insurance application. **I understand that my representative can use this information to recommend an insurance product that may be better suited to my situation or to help explain the underwriting decisions that are made.**

I understand that supplementary personal information may include details about:

a) results from medical exams or lab tests;
b) my health, including specific illnesses or health problems (e.g., mental illnesses, infectious diseases, use of prescription drugs, illicit drugs or alcohol), treatments I've received, or rehabilitation programs I've participated in;
c) my health uncovered in the insurance application process, even if this information was unknown to me at the time I submitted my insurance application;
d) my work history or financial situation;
e) violations of the Highway Safety Code or other similar laws;
f) Criminal Code offences, etc.

2- By signing this authorization form, I understand and acknowledge the following:

a) I have read and understood the nature and scope of this authorization;
b) I authorize Desjardins Insurance to disclose supplementary personal information about myself to my representative and their financial centre administrative staff;
c) Desjardins Insurance reserves the right not to disclose highly confidential personal details to my representative or their financial centre administrative staff;
d) I can revoke this authorization at any time by calling Desjardins Insurance at **1-877-315-8484;**
e) This authorization will remain valid for 60 days after the latest of the following dates:
   - the date on which Desjardins Insurance issues a new insurance contract or amends an existing contract;
   - the date on which Desjardins Insurance offers to issue a new insurance contract or amend an existing contract; or
   - the date on which Desjardins Insurance sends me notice that my insurance application has been cancelled, declined or deferred.

The following people have read this authorization before signing it:

- each proposed insured age **14 or older** (Quebec) or **16 or older** (provinces other than Quebec);
- each person authorized to sign on behalf of a proposed insured **under age 14** (Quebec) or **under age 16** (provinces other than Quebec).

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

X _____ _____
Signature of proposed insured 1 — Date (yyyy/mm/dd)

X _____ _____
Signature of proposed insured 2 — Date (yyyy/mm/dd)

Proposed insured **under age 14** (Quebec) or **under age 16** (provinces other than Quebec)

The signature of a parent, guardian or legal representative is required for this person.
Person signing: ☐ Parent (father or mother) ☐ Guardian (Quebec) ☐ Legal representative (provinces other than Quebec)

_____ X _____ _____
First and last names of the person signing for proposed insured 1 (please print) — Signature — Date (yyyy/mm/dd)

_____ X _____ _____
First and last names of the person signing for proposed insured 2 (please print) — Signature — Date (yyyy/mm/dd)

A photocopy of this authorization form is as valid as the original. Please return the completed form to Desjardins Insurance by fax at **1-800-941-4861.**

P - Receipt for the initial premium - If applicable, give this receipt to the policyowner.

Desjardins Insurance acknowledges receipt of the amount of $ _____ from _____ by automatic withdrawal or by cheque. This amount is the total of initial premiums needed for the agreements in case of death, critical illness or disability to take effect, whichever is applicable.

X _____ X _____ _____
Signature of representative ☐ Check if trainee — Signature of supervisor (Quebec only) — Date (yyyy/mm/dd)

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Q - Statements and authorizations

1- The policyowner and the proposed insureds declare 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 contract(s) based on these answers and statements.

2- The policyowner and the proposed insureds agree to notify Desjardins Insurance of any change that may affect the insurability conditions of the proposed insureds 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 healthcare professional, a recommendation to have a medical appointment or consultation with a healthcare 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- Each proposed insured agrees to have insurance being issued on them.

4- The policyowner acknowledges that:

a) they were given an accurate description of the coverages applied for;
b) the exclusions applicable to the coverages were clearly explained;
c) they received the illustration outlining the values and features of the coverages applied for, or the representative went over the illustration with them;
d) the information provided on their "Declaration of tax residence" is correct and complete (if applicable). They agree to give Desjardins Insurance a new declaration within 30 days in the event of any change in circumstances;
e) they will provide Desjardins Insurance any business or trust number missing from **section A2 – Policyowner only** (page 2) within 90 days;
f) they will provide Desjardins Insurance, within 90 days, a copy of any valid cannabis licence issued by Health Canada and, if required because of the nature of their business activities, by the Canada Revenue Agency;
g) the representative has disclosed or provided in writing to the policyowner 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 policyowner and the proposed insureds acknowledge that:

a) any misrepresentation, including the misrepresentation of smoking habits, may void the contract;
b) they have read and received a copy of **sections M - Notice Applicable to MIB, LLC** and **N - Personal information management** (pages 27 and 28).

6- The policyowner and the proposed insureds confirm that they read this section before signing it.

7- **For a Temporary insurance agreement:** the policyowner and the proposed insureds acknowledge having read the **Temporary insurance agreement in case of death** or the **Temporary insurance agreement in case of critical illness** and acknowledge understanding the terms and conditions stipulated in the applicable agreement(s). Each proposed insured declares not being affected by the exclusions or conditions mentioned in the applicable agreement(s).

8- **For the Conditional insurance agreement:** the policyowner and the proposed insureds acknowledge having read the **Conditional insurance agreement in case of disability** and acknowledge understanding the terms and conditions stipulated in said agreement. Each proposed insured declares not being affected by the exclusions or conditions mentioned in the Conditional insurance agreement in case of disability.

Note: The duly completed Identity Verification Supplementary Form (08295E) and the supporting documents requested on that form must be attached to the application in the following situation:

a) the policyowner is a corporation, trust or other entity; and
b) life insurance coverage with cash surrender values or a savings component is applied for.

Signed at (city or town, province) _____ Date (yyyy/mm/dd) _____

X _____
Signature of policyowner

☐ **Policyowner 1** identified in **section A1**
☐ Policyowner identified in **section A2** (Individual)
☐ Person authorized to sign on behalf of the policyowner identified in **section A2** (Corporation, trust or other entity)

X _____
Signature of second policyowner (if applicable)

☐ **Policyowner 2** identified in **section A1**
☐ Policyowner identified in **section A2** (Individual)
☐ Person authorized to sign on behalf of the policyowner identified in **section A2** (Corporation, trust or other entity)

X _____
Signature of proposed insured 1

X _____
Signature of proposed insured 2

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 other than Quebec)

First and last names of the person signing for proposed insured 1 (please print) _____ X _____ Signature _____ Date (yyyy/mm/dd)

First and last names of the person signing for proposed insured 2 (please print) _____ X _____ Signature _____ Date (yyyy/mm/dd)

Desjardins Insurance refers to Desjardins Financial Security Life Assurance Company.

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Q - Statements and authorizations (cont.)

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 H** (page 21) of this application. Moreover, I acknowledge having read the terms and conditions regarding the PAD in **section H** (page 21) 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 the second account holder (only if 2 signatures are required) — Date (yyyy/mm/dd)

Consent for changes requested, 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 **section D** (page 7) of 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)

Desjardins Insurance refers to Desjardins Financial Security Life Assurance Company.

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R - Specific consent

Applicable to Quebec only

When one of our representatives offers you financial products such as insurance and annuities, we wish to obtain from you certain relevant information of a personal and/or financial nature. For specifics on the content of each of these information categories, please read the other side of this page. Please authorize, in the table below, the “Required information categories to be accessed” for which you give consent.

After reading the Notice of specific consent shown on the back, I, the undersigned, agree that the information that Desjardins Financial Security, Financial Services Firm holds concerning me be used at the time of the financial services offer of insurance and annuities.

This consent will be valid until it is cancelled or until the cancellation date indicated below.

Identification and signature – policyowner and insured		**Required information categories to be accessed and client’s authorization**		
First and last names	Date of birth (yyyy/mm/dd)	Personal	☐ Yes ☐ No	Cancellation date (if applicable)
Signature X	Date of signature (yyyy/mm/dd)	Financial	☐ Yes ☐ No	
First and last names	Date of birth (yyyy/mm/dd)	Personal	☐ Yes ☐ No	Cancellation date (if applicable)
Signature X	Date of signature (yyyy/mm/dd)	Financial	☐ Yes ☐ No	
First and last names	Date of birth (yyyy/mm/dd)	Personal	☐ Yes ☐ No	Cancellation date (if applicable)
Signature X	Date of signature (yyyy/mm/dd)	Financial	☐ Yes ☐ No	
First and last names	Date of birth (yyyy/mm/dd)	Personal	☐ Yes ☐ No	Cancellation date (if applicable)
Signature X	Date of signature (yyyy/mm/dd)	Financial	☐ Yes ☐ No	
First and last names	Date of birth (yyyy/mm/dd)	Personal	☐ Yes ☐ No	Cancellation date (if applicable)
Signature X	Date of signature (yyyy/mm/dd)	Financial	☐ Yes ☐ No	
First and last names	Date of birth (yyyy/mm/dd)	Personal	☐ Yes ☐ No	Cancellation date (if applicable)
Signature X	Date of signature (yyyy/mm/dd)	Financial	☐ Yes ☐ No	

In accordance with the *Act Respecting the Protection of Personal Information in the Private Sector*, **you may request access to the information that we hold pertaining to you.**

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R - 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	Postal code	10-digit phone number

I hereby revoke the specific consent given to:

Desjardins Financial Security, Financial Services Firm
200, rue des Commandeurs, Lévis (Québec) G6V 6R2

by the following notice:

On _____
(yyyy/mm/dd)

I, the undersigned, _____, hereby notify you that I am
Policyowner's or insured's first name and last name

cancelling the specific consent authorizing the communication of my personal information for new purposes.

Consent given to you on: _____
Date of consent (yyyy/mm/dd)

X _____
Signature of policyowner or insured

Desjardins Insurance
Life • Health• Retirement

S - Representative information and declaration

Compensation: ☐ Career ☐ Accelerated ☐ Not applicable

The representative declares that:

1- the policyowner 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 policyowner 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- they have disclosed in writing to the policyowner 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.

Representative's first name	Representative's last name	Representative code	Field office code
Email		Share %	Check if trainee ☐
Representative's first name	Representative's last name	Representative code	Field office code
Email		Share %	Check if trainee ☐
Representative's first name	Representative's last name	Representative code	Field office code
Email		Share %	Check if trainee ☐

Is the representative the proposed insured or the policyowner?	☐ Yes ☐ No

X _____ _____
Signature of representative — Date (yyyy/mm/dd)

QUEBEC ONLY - If the representative is a trainee, please complete this section.

First name of supervisor	Last name of supervisor	Representative code	Field office code
Email			

X _____ _____
Signature of supervisor (Quebec only) — Date (yyyy/mm/dd)

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Referrals

1

First and last names		Age	Employer
Spouse's first and last names		Age	First name of children
Address (No., street, apt.)			10-digit phone number Home: _____ Cell.: _____
City	Province	Postal code	Work: _____, ext.: _____

2

First and last names		Age	Employer
Spouse's first and last names		Age	First name of children
Address (No., street, apt.)			10-digit phone number Home: _____ Cell.: _____
City	Province	Postal code	Work: _____, ext.: _____

3

First and last names		Age	Employer
Spouse's first and last names		Age	First name of children
Address (No., street, apt.)			10-digit phone number Home: _____ Cell.: _____
City	Province	Postal code	Work: _____, ext.: _____

4

First and last names		Age	Employer
Spouse's first and last names		Age	First name of children
Address (No., street, apt.)			10-digit phone number Home: _____ Cell.: _____
City	Province	Postal code	Work: _____, ext.: _____