Desjardins Insurance
Life • Health • Retirement

1, Complexe Desjardins
Montréal (Québec) H5B 1E2
1-800-278-0669

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

Insurance Application
SOLO Essential Disability Income

☐ New business ☐ Request for change(s)

Reset Print

Contract number:	Reference number:

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

IMPORTANT: For SOLO Essential Disability Income, **the policyowner must be the proposed insured** and be age 18 or older.
For readability purposes, we have used "you" in this insurance application.

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A - Information about proposed insured (policyowner)

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

10-digit phone number

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

Do you speak and understand English? ☐ Yes ☐ No

If **no,** please specify your language and answer the question below: _____

Who will be explaining the contents of this insurance application in your language? (**Note:** This person cannot be a beneficiary named in the application.)

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

First name	Last name	Relationship to you

Representative use only – Verification of proposed insured identity

☐ 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	Expiry (yyyy/mm/dd) (an expired ID is not valid)	Date ID checked (yyyy/mm/dd)
Province, territory or state: _____ Country: _____		

B - Pre-requisites for SOLO Essential Disability Income

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

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

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

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

C - Occupation

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

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

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

Primary occupation	Description of responsibilities
Secondary occupation	Description of responsibilities

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

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

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

What type of driver are you? _____

What is your cargo? _____

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

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D - Coverages applied for

Check the desired coverages and fill out all the required sections of this form.

SOLO Essential Disability Income	Coverage type		Waiting period			Benefit period		Monthly benefit*
	24 hours	Non-work-related	0 days	30 days	120 days	5 years	To age 70	
Accident	☐	☐	☐	☐	☐	☐	☐	$
Illness	☐		☐	☐	☐	☐	☐	$
Accidental Fracture	☐							
Accidental Death, Dismemberment or Loss of Use	☐ $100,000		☐ $200,000		☐ $300,000	☐ $400,000		☐ $500,000

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

E - Changes to an in-force contract

Check the desired changes and fill out all the required sections of this form for those changes.

Change requested

☐ Add a coverage – Check the applicable coverage:

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

☐ Extend benefit period to: ☐ Age 70 Coverage: ☐ Accident ☐ Illness

☐ Reduce benefit period to: ☐ 5 years Coverage: ☐ Accident ☐ Illness

☐ Extend waiting period to: ☐ 30 days ☐ 120 days Coverage: ☐ Accident ☐ Illness

☐ Reduce waiting period to: ☐ 0 days ☐ 30 days Coverage: ☐ Accident ☐ Illness

☐ Increase the monthly benefit amount – Check the applicable coverage: ☐ Illness or ☐ Accident

- Monthly benefit amount:* $_____
- Benefit period: ☐ 5 years ☐ To age 70
- Waiting period: ☐ 0 days ☐ 30 days ☐ 120 days

* The monthly benefit cannot exceed the eligible monthly benefit indicated in item (C) of **section G**.

☐ Reduce the monthly benefit amount – Check the applicable coverage: ☐ Illness or ☐ Accident

- Monthly benefit amount:* $_____ (per increment of $100, minimum of $500)
- Benefit period: ☐ 5 years ☐ To age 70
- Waiting period: ☐ 0 days ☐ 30 days ☐ 120 days

* The monthly benefit cannot exceed the eligible monthly benefit indicated in item (C) of **section G**.

☐ Change from **Accident – 24 hours** to **Accident – Non-work-related** coverage

- Benefit period: ☐ 5 years ☐ To age 70
- Waiting period: ☐ 0 days ☐ 30 days ☐ 120 days

☐ Change from **Accident – Non-work-related** to **Accident – 24 hours** coverage

- Benefit period: ☐ 5 years ☐ To age 70
- Waiting period: ☐ 0 days ☐ 30 days ☐ 120 days

F - Insurance in force

Are you submitting this application to replace a coverage issued by Desjardins Insurance or by another insurer? ☐ Yes ☐ No
If **yes,** please complete a notice or prior notice of replacement according to your province's or territory's regulations, if required.

Do you currently have any Accidental Death, Dismemberment or Loss of Use insurance? ☐ Yes ☐ No
If **yes,** indicate the total insurance amount that you have a) With Desjardins Insurance: _____ b) With other insurers: _____

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G - Pre-requisites for Illness coverage

G1 - Medical conditions

⚠ If you answer **yes** to **questions 1**, **2** or **3**, you are not eligible for the **Illness** coverage.

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

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

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

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

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

G2 - Height and weight

⚠ If your weight is less than the minimum or exceeds the maximum indicated in the table below for your height, you are not eligible for the **Illness** coverage.

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

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

H - Eligibility for Illness coverage

H1 - Identification of the attending physician

- Indicate the contact information of the attending physician who has your medical records.

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

H2 - Family history

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

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

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

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H - Eligibility for Illness coverage (cont.)

H3 - Alcohol and drug use

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

H4 - Criminal history

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

H5 - Specific medical conditions

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

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

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

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

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

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

If you answered **yes** to any question from **sections H4** and **H5,** please give full and accurate details below. Include the question number, symptoms, diagnosis, treatment date, duration of each occurrence and physicians who have treated you. Indicate if any time was lost from work and whether recovery is complete or not. If you are not fully recovered, provide details of any ongoing issues, treatment, problems or follow-ups. Please include details regarding any criminal offence.

No.	Details

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I - Examinations ordered by the representative

Instructions for the representative:

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

Paramedical firm

☐ Dynacare Insurance Solutions ☐ ExamOne ☐ Other:

Examinations ordered

☐ Paramedical exam ☐ Blood profile ☐ Urine test

J - Annual income

Employee	**Annual income (current year)** $
Worker paid on commission	**Annual income** (Net income reported on your T1: lines 13500 to 14300) $

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

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

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

First and last names of the beneficiary	**Date of birth (yyyy/mm/dd)**	**Relationship between the beneficiary and:** **- the policyowner,** for contracts issued in Quebec **- the proposed insured,** for contracts issued in provinces or territories other than Quebec	**Sex**	**Status**
First name Last name		☐ Married ☐ Civil union spouse (Quebec only) ☐ Common-law spouse ☐ Other:	☐ F ☐ M	☐ Revocable ☐ Irrevocable

First and last names of the trustee for a minor beneficiary*	**Date of birth (yyyy/mm/dd)**	**Relationship between the trustee and the beneficiary**	**Sex**
First name Last name			☐ F ☐ M

* For provinces or territories other than Quebec

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L - Paying for the insurance

Premium information

☐ Annual premium: $_____ **OR** ☐ Monthly premium: $_____

Payment method

⚠ Check **1 box only** to indicate how you want to make your contract's **recurring payments**.

☐ **Pre-authorized debits** – Complete the **Recurring payments** section of the **09312E – Pre-Authorized Debit (PAD) Agreement** form.

☐ **Credit card –** The credit cardholder must call 1-800-278-0669.
Important: To pay by credit card, the payment frequency must be **annual** ($10,000 maximum).

_____ X _____ _____
First and last names of credit cardholder | Signature of credit cardholder | Date (yyyy/mm/dd)

By signing above, I confirm that I am the credit cardholder and I agree to the card being used to pay the amount indicated in this section.

☐ **Cheque** – Please attach a cheque made out to Desjardins Insurance.
Important: To pay by cheque, the payment frequency must be **annual**.

Desjardins Insurance refers to Desjardins Financial Security Life Assurance Company.

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M - Notice applicable to MIB, LLC

Who is MIB, LLC?

MIB, LLC ("MIB") operates an information exchange on behalf of insurance companies that are members of MIB Group Inc. and with operations in Canada and the United States. The organization operates a database of consumer reports, which are comprised of information contributed by member insurance companies.

What information do we exchange, and why?

Like almost every Canadian insurer that offers life and health insurance, Desjardins Insurance is a member of MIB and can exchange information about you with the organization.

MIB makes it possible to verify the accuracy and completeness of the information provided by clients of member insurance companies.

We only exchange information on factors that could have a serious effect on your health or life expectancy. These factors include:

- Serious medical conditions
- A dangerous hobby
- A poor driving record
- Alcohol or drug use
- A criminal record

The information we contribute to MIB then becomes available to other MIB member insurance companies. MIB generally keeps this information on file for 7 years.

When do we exchange this information?

When we receive:

- An insurance application about you
- A claim

Also, if another member company receives an insurance application about you within 2 years following our receipt of this insurance application, we may share information with MIB for the benefit of that member company.

Your personal information is protected

MIB is bound by the same personal information confidentiality requirements as other Canadian insurers and must respect all federal and provincial privacy laws.

Since MIB is based in the United States, your information could be transferred outside Canada. Note that MIB must also comply with US privacy laws.

To learn more, review MIB's Consumer Privacy Policy at **www.mib.com/privacy_policy.html**.

You have the right to access your personal information and correct any inaccuracies, if necessary

To do so, contact MIB directly in one of the following ways:

- By email canadadisclosure@mib.com
- By phone 1-866-692-6901
- By mail MIB, LLC
  50 Braintree Hill Park, Suite 400
  Braintree MA 02184-8734 USA
- Website www.mib.com

Desjardins Insurance refers to Desjardins Financial Security Life Assurance Company.

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N - Consent related to the management of your personal information by Desjardins Group

1. Management of your personal information

To serve you on a daily basis and meet our legal obligations, we need to collect, use and disclose information about you. For more details, see Desjardins Group's Privacy Policy at www.desjardins.com/privacy-policy.

You may be asked for specific consent to ensure that Desjardins Insurance can deliver or continue to deliver service. This will be done in compliance with Desjardins Group's Privacy Policy.

Desjardins Insurance handles all your personal information confidentially. Your information will be accessed only by employees who require it to complete their tasks.

2. Your rights

You can:

- See the personal information Desjardins Group has about you
- Correct any information that's incomplete, ambiguous or not relevant

To find out how, see Desjardins Group's Privacy Policy.

3. Collection or transfer of your personal information outside of Canada

Desjardins Insurance uses service providers located outside of Canada to perform certain specific activities in its normal course of business. As such, personal information may be collected in and/or transferred to another country and be subject to the laws of that country.

For information about our policies and practices regarding the collection and transfer of personal information outside of Canada, see Desjardins Group's Privacy Policy. You can also obtain this information, or ask any questions you might have, by calling us at 1-800-278-0669.

By signing below, you:

- Acknowledge that you've looked at Desjardins Group's Privacy Policy, which is available at www.desjardins.com/privacy-policy
- Authorize Desjardins Group to collect, use and disclose your personal information based on the conditions outlined in the policy and applicable regulations
- Acknowledge and accept that this consent takes precedence over any other consent you've previously signed
- Acknowledge that this consent remains valid for as long as you have a business relationship with a Desjardins Group component

X _____ Signature of the proposed insured (policyowner)

_____ Signed at (city or town, province or territory)

_____ Date (yyyy/mm/dd)

Desjardins Insurance refers to Desjardins Financial Security Life Assurance Company.

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

1. Why Desjardins Insurance needs your consent

Your consent allows us to collect, use and disclose the personal information we require to:

1. Analyze your insurance applications
2. Manage your file while you're covered under the insurance
3. Process claims

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

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

  MIB, LLC is an organization that operates a database allowing insurance companies in Canada and the United States to collect and disclose information about their clients.
- Send your doctor any medical information that we obtained about you when analyzing your insurance applications or claims, so they can share it with you.
- Provide insurers and reinsurers with any relevant information (medical test results, etc.), so they can assess an insurance application you've submitted.

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

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

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

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

By signing below, you authorize Desjardins Insurance and its reinsurers to collect, use and disclose your personal information based on the conditions outlined in this section, the applicable regulations and Desjardins Group's Privacy Policy. You can consult the policy at www.desjardins.com/privacy-policy.

X _____
Signature of the proposed insured (policyowner)

_____
Signed at (city or town, province or territory)

_____
Date (yyyy/mm/dd)

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P - Statements and authorizations

1- You declare that all answers and statements provided in this application, or in any other questionnaire or form relating to it, are true and complete. You understand that the contract will be issued based on these answers and statements.

You also understand that the contract will be issued based on all additional information collected by Desjardins Insurance concerning your insurability in order to review the application (questionnaires, examinations, tests, phone interviews, etc.).

2- You agree to notify Desjardins Insurance of any change that may affect your insurability between the date the application is signed and the effective date of the coverages applied for, as defined in the General provisions of the contract to be issued. Such a change may include:

- A change in health status
- An illness, disease, disorder, injury, operation or treatment
- A consultation, examination or treatment by any healthcare professional
- A recommendation for a medical appointment or consultation with a healthcare professional that has not yet taken place
- A medical test or recommendation to have a medical test of any kind that has not yet taken place
- An accident
- A change in occupation, tasks or responsibilities
- A change in lifestyle habits:
  - Use of tobacco, nicotine products, alcohol, cannabis, etc.
  - Participation in hazardous sports
  - Travel or stay outside Canada or the United States
- A Highway Safety Code offence (or any offence to other similar laws)
- A Criminal Code offence
- Etc.

3- You agree to have insurance issued on yourself.

4- You acknowledge that:

a) you were given an accurate description of the coverages applied for and their nature;
b) the exclusions applicable to the coverages were clearly explained to you;
c) you received the illustration outlining the features of the coverages applied for, or the representative went over the illustration with you;
d) the representative has disclosed in writing the names of all life and health insurance companies on whose behalf they sell products, that they receive commissions or a salary for the sale of their life and health insurance products and that they may qualify for additional compensation, such as bonuses, or non-monetary benefits, such as participation in conferences or other recognition activities.

5- You acknowledge that any misrepresentation may void the contract.

6- You acknowledge that you have read **section L - Notice applicable to MIB, LLC** (page 9).

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

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

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

10- **If this application is signed in Quebec:** unless the contract is issued as the result of a modification, you understand that you will receive a French version of all the documents forming your contract and ask that these documents and any future documents regarding the insurance applied for be provided to you in English.

Si cette proposition est signée au Québec : *sauf si le contrat est établi à la suite d'une modification, vous comprenez que vous recevrez une version française de tous les documents qui constituent votre contrat et demandez que ces documents et tout document futur relatif à l'assurance demandée vous soient fournis en anglais.*

11- You confirm that you have read this section before signing it.

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

Irrevocable beneficiary's and creditor's consent

⚠ This section has to be signed only if a **change** or **changes** are made to the contract.

Irrevocable beneficiary of the Accidental Death, Dismemberment or Loss of Use coverage: I state that I authorize all changes requested in this form, including revoking my designation as irrevocable beneficiary, where applicable.

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

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

Creditor who holds a guarantee on the contract: I state that I authorize all changes requested in this form.

_____ X _____ _____ _____
Name of creditor | Signature | Signed at (city or town, province or territory) | Date (yyyy/mm/dd)

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Q - Representative information and declaration

Compensation: ☐ Career ☐ Accelerated ☐ Not applicable

The representative declares that:

1- the proposed insured (policyowner) has read all the questions in this application and that, to the best of the representative's knowledge, the answers are true and complete;

2- they have seen the proposed insured (policyowner) and they have duly confirmed their identity;

3- they have disclosed or provided in writing to the proposed insured (policyowner) the names of all life and health insurance companies on whose behalf they sell products, that they receive commissions or a salary for the sale of their life and health insurance products and that they may qualify for additional compensation, such as bonuses, or non-monetary benefits, such as participation in conferences or other recognition activities;

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

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?	☐ 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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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.

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

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

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

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

Desjardins
Insurance
Life • Health • Retirement

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 or territory	Postal code	10-digit phone number

I hereby revoke the specific consent given to:

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

by the following notice:

On _____
(yyyy/mm/dd)

I, the undersigned, _____, hereby notify you that I am
Insured's (policyowner's) first name and last name

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

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

X _____
Signature of insured (policyowner)

Desjardins Insurance refers to Desjardins Financial Security Life Assurance Company.