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

Add or change Additional Deposit Option (ADO)

Contract number:

Use this form to:

Provide new deposit instructions to: • Stop deposits • Make a one-time deposit • Reduce the deposit amount • Increase the deposit amount up to the permitted annual deposit	Go to **section A**
Make changes to an eligible contract to: • Add ADO • Increase the deposit amount to more than the permitted annual deposit	Go to **section B**

A – To provide new deposit instructions

Please check the appropriate box, provide the payment information in section H (if applicable) and sign section M.

☐ Stop deposits

☐ Make a one-time deposit Indicate the amount in **section H2 – Other payment or reimbursement**

☐ Reduce the deposit amount

☐ Increase the deposit amount up to the permitted annual deposit

Deposit amount	
From	To
$______ Annual amount	$______ Annual amount

If the payment frequency selected to pay the contract premiums is monthly, the deposit amount entered will be divided by 12.

B – To make changes to an eligible contract

Please read before completing this section

1. Attach an illustration to this form.
2. If the contract includes joint coverage and the insured persons must complete one or more of sections C through G, use a separate form for each insured person.
3. If the contract to be modified includes eligible **participating life insurance** for which the insured person has provided evidence of insurability and if, at the time of the request:
   - The contract has been in force for **less than 5 years:**
     - Don't answer the questions about the insured person's health and lifestyle habits (sections C through G)
     - Complete sections B and H, and sign section M—the representative must also complete section N.
   - The contract has been in force for **5 or more years,** has **no exclusions or extra premiums** and the permitted annual deposit or the increase requested is **less than $100,000:**
     - Complete from section B onwards.

See **Add or change Additional Deposit Option (ADO)** on the **In-force administration** page of *webi* to check whether the contract to be modified meets the **eligibility conditions.** In that section, you'll also find information on which form needs to be completed for a contract that was issued or will be issued by **exercising an option** or for **any other contract** to be modified.

Please check the appropriate box and indicate the amount requested.

☐ Add ADO to an in-force contract — Permitted annual deposit: $______ Annual amount

Please be sure to send us your request 30 to 60 days before the contract's anniversary date since the ADO will be added on that date.

☐ Add ADO to a new contract issued by exercising an option — Permitted annual deposit: $______ Annual amount

☐ Increase the deposit amount to more than the permitted annual deposit of an in-force contract

Permitted annual deposit amount	
From	To
$______ Annual amount	$______ Annual amount

Please be sure to send us your request 30 to 60 days before the contract's anniversary date since the deposit amount will be increased on that date.

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C – Insured person

⚠ **IMPORTANT! Any personal information that the insured person provides in sections C, D, E, F and G, or in any other questionnaire or form relating to any of those sections, will be disclosed to the policyowner.**

First name	Last name

Date of birth (yyyy/mm/dd)	Height	Weight
	_______ cm or ___ ft ___ in	_______ kg or _______ lb

Do you speak and understand English? ☐ ☐ No

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

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

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

First name	Last name	Relationship to you

D – Questions for the insured person

D – Questions for the insured person	Yes	No
1- Have you used any form of **tobacco or nicotine products** (cigarettes, cigarillos, cigars, pipes, electronic cigarettes, nicotine gum or nicotine patches) or anti-smoking medication in the **past 12 months**? If you answered **No** and you are a former smoker, what is the date you last used a tobacco or nicotine product (yyyy/mm/dd)? ____________________	☐	☐
2- **In the past 10 years,** for any of the conditions listed below, have you consulted a physician or other healthcare professional, been advised to undergo tests or exams, received a diagnosis, or been advised to take medication or receive any other treatment? If you answered **Yes,** please provide details in **section E.** **Conditions:** abnormality of the immune system (including AIDS and a positive HIV test), bladder or kidney disorders, brain or neurological disorders (including stroke), cancer or tumour (including melanomas), diabetes, heart disease (chest pain, heart attack, heart murmur, etc.), hepatitis or cirrhosis of the liver, respiratory disorders (including asthma and sleep apnea).	☐	☐
3- **In the past 10 years,** for any condition not listed in **question 2,** have you been admitted to a healthcare facility for more than 72 consecutive hours or been absent from work for more than 4 consecutive weeks? (Answer **No** if you were on maternity or paternity leave.) If you answered **Yes,** please provide details in **section E.**	☐	☐
4- Have you ever experienced or are you currently experiencing discomfort, symptoms or conditions that you haven't already mentioned for which you: haven't consulted a physician or other healthcare professional or are waiting to consult one; have been advised to take medication or undergo surgery, tests or exams that have yet to be completed or for which you're currently awaiting results? If you answered **Yes,** please provide details in **section E.**	☐	☐
5- **In the past 10 years,** have you used cannabis? If you answered **Yes,** specify the type of use, quantity and frequency in **section F.**	☐	☐
6- **In the past 10 years,** have you used drugs (other than cannabis) or opioids that were not prescribed by a physician or healthcare professional? If you answered **Yes,** specify the type of drug/opioid and the quantity and frequency of use in **section F.**	☐	☐

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E – Important additional information for questions D–2, D–3 and D–4

Discomfort, symptom or condition	Date (yyyy/mm/dd)	Name of medication or treatment	Results and current status	Name and address of physician or healthcare facility

F – Important additional information for questions D–5 and D–6

Question D–5 – Cannabis use	Quantity	Frequency	Period of use (yyyy/mm/dd)	
Please select the option that applies to your situation: ☐ Recreational use ☐ Medical use ☐ Recreational and medical use			From:	To:
Question D–6 – Type of drug/opioid	**Quantity**	**Frequency**	**Period of use (yyyy/mm/dd)**	
			From:	To:
			From:	To:

G – Insured person’s personal physician

First and last names of physician

Address (No., street, apt.)		City	
Province or territory	Postal code	10-digit phone number	Date of last visit (yyyy/mm/dd)

Reason for last visit and results

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H – Paying for the insurance

ⓘ Please complete this section to:

- Add ADO to the contract or increase the deposit amount to more than the permitted annual deposit
- Make changes to the payment method or frequency of the contract to be modified.

H1 – Payment for contract to be modified

Premium and deposit information

Payment frequency: ☐ Monthly ☐ Annual ☐ Semi-annual

ⓘ Enter **0** on the **Deposit** line if you do not want to make a deposit at the same time as the premium payment.

Premium and deposit based on chosen frequency:

Premium: $________________

Deposit: $________________

Total of the premium and deposit: $________________

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 must include the **annual premium and deposit** ($10,000 maximum).

First and last names of credit cardholder	X 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 **semi-annual** or **annual**.

H2 – Other payment or reimbursement

- Please complete this section to make a one-time payment or reimbursement related to the contract to be modified.

Payment or reimbursement type	Payment method
☐ One-time deposit for the **Additional Deposit Option** coverage Amount: $________________	☐ **Pre-authorized debit** Complete the One-time payment section of the **09312E – Pre-Authorized Debit (PAD) Agreement** form. OR ☐ **Cheque** Please attach a cheque made out to Desjardins Insurance.
☐ Repayment of a contract loan Amount: $________________	☐ **Pre-authorized debit** Complete the One-time payment section of the **09312E – Pre-Authorized Debit (PAD) Agreement** form. OR ☐ **Cheque** Please attach a cheque made out to Desjardins Insurance.
☐ Deposit into a **Premium Deposit Account** for premium payment purposes Amount: $________________ Provide instructions for withdrawing the recurring amount from the **Premium Deposit Account**: ________________________________ ⓘ Some conditions may apply to using the account.	☐ **Pre-authorized debit** Complete the One-time payment section of the **09312E – Pre-Authorized Debit (PAD) Agreement** form. OR ☐ **Cheque** Please attach a cheque made out to Desjardins Insurance.

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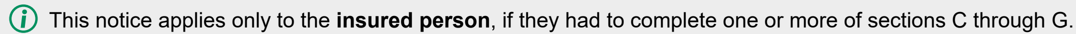
I – Notice applicable to MIB, LLC – Give to the insured person



This notice applies only to the **insured person**, if they had to complete one or more of sections C through G.

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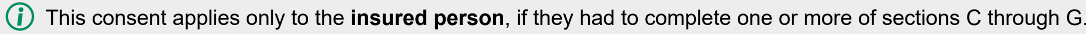
J – Consent related to the management of your personal information by Desjardins Insurance


This consent applies only to the **insured person**, if they had to complete one or more of sections C through G.

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

3. If the application concerns your children

You authorize us to collect, use and disclose the necessary information about them, if they're under age 14 (Quebec) or under age 16 (all other provinces and territories).

By signing the next page, 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.

Please sign the next page

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J – Consent related to the management of your personal information by Desjardins Insurance (cont.)

Signed at (city, province or territory)

Insured person age **14 or older** (Quebec) or **16 or older** (provinces or territories other than Quebec)

X
Signature of insured person

Date (yyyy/mm/dd)

If the insured person is **under age 14** (Quebec) or **under age 16** (provinces or territories other than Quebec), the signature of a parent, guardian or legal representative is required.

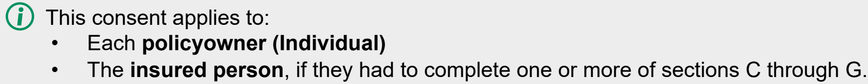
Person signing: ☐ Parent (father or mother) ☐ Guardian (Quebec) ☐ Legal representative (provinces or territories other than Quebec)

First and last names of the person signing (please print)

X
Signature

Date (yyyy/mm/dd)

K – Consent related to the management of your personal information by Desjardins Group



This consent applies to:
- Each **policyowner (Individual)**
- The **insured person**, if they had to complete one or more of sections C through G.

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 this section, 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

Please sign the next page

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K – Consent related to the management of your personal information by Desjardins Group (cont.)

Signed at (city, province or territory)

Policyowner(s)

First and last names of policyowner (Individual) | X Signature of policyowner | Date (yyyy/mm/dd)

First and last names of second policyowner (Individual), if applicable | X Signature of second policyowner | Date (yyyy/mm/dd)

Insured person age **14 or older** (Quebec) or **16 or older** (provinces or territories other than Quebec)

X Signature of insured person | Date (yyyy/mm/dd)

If the insured person is **under age 14** (Quebec) or **under age 16** (provinces or territories 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 or territories other than Quebec)

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

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L – Authorization to disclose supplementary personal information to the representative

- This authorization applies only to the **insured person,** if they had to complete one or more of sections C through G.
- You don't need to complete this section when submitting this form. However, the insured person will have to provide this authorization if you ask us to disclose their personal information to your representative while we're reviewing your request or afterwards.

Note: For the purposes of this form, the term "representative" refers to the representative the policyowner does business with.

Insured person	
First and last names	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 in-force contract
   - The date on which Desjardins Insurance offers to issue a new insurance contract or amend an in-force 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:

- The insured person age **14 or older** (Quebec) or **16 or older** (provinces or territories other than Quebec)
- The person authorized to sign on behalf of the insured person **under age 14** (Quebec) or **under age 16** (provinces or territories other than Quebec).

Insured person age 14 or older (Quebec) or 16 or older (provinces or territories other than Quebec)

X ______________________ Signature of insured person ______________ Date (yyyy/mm/dd)

Insured person under age 14 (Quebec) or under age 16 (provinces or territories 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 or territories other than Quebec)

______________________ First and last names of the person signing for insured person (please print) X ______________________ 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.**

Desjardins Insurance refers to Desjardins Financial Security Life Assurance Company.

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M – Statements and authorizations

- Each policyowner must make the applicable statements below and sign at the end of this section.
- The insured person must make the applicable statements below and sign at the end of this section only if they had to complete one or more of sections C through G.

1. If one or more of sections C through G had to be completed:
   - The policyowner and the insured person declare that all answers and statements provided in this form, or in any other questionnaire or form relating to it, are true and complete. They understand that the contract will be modified based on these answers and statements.

     They also understand that the contract will be modified based on all additional information collected by Desjardins Insurance concerning the insurability of the insured person in order to review this request (questionnaires, examinations, tests, phone interviews, etc.).
   - The policyowner and the insured person agree to notify Desjardins Insurance of any change in the insurability of the insured person between the date the form is signed and the effective date of the requested change. 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
       - Trip 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.
   - The policyowner and the insured person acknowledge that any misrepresentation, including the misrepresentation of the use of tobacco or nicotine products, may void the change requested.
   - The insured person agrees to have their personal information on this form, or on any other questionnaire or form relating to it, disclosed to the policyowner.
   - The insured person acknowledges that they have received and read **section I – Notice applicable to MIB, LLC.**
2. The policyowner and the insured person have read this section before signing it.
3. If the policyowner wants to add ADO to the contract or increase the deposit amount to more than the permitted annual deposit, they acknowledge that:

   a) They were given an accurate description of the product and a detailed explanation of the change requested

   b) The applicable exclusions were clearly explained

   c) They received or were presented the illustration outlining the values associated with the change requested and the features of ADO.

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M – Statements and authorizations (cont.)

Signed at (city, province or territory)

Policyowners (Individuals)

First and last names of policyowner (please print)

X Signature of policyowner

Date (yyyy/mm/dd)

First and last names of second policyowner, if applicable (please print)

X Signature of second policyowner

Date (yyyy/mm/dd)

Policyowner (Corporation, trust or other entity)

Name of the “Corporation, trust or other entity” policyowner

Name and title of the person authorized to sign on behalf of the “Corporation, trust or other entity” policyowner (please print)

X Signature of the person authorized to sign on behalf of the “Corporation, trust or other entity” policyowner

Date (yyyy/mm/dd)

Insured person age **18 or older** (Quebec) or **16 or older** (provinces or territories other than Quebec)

X Signature of insured person

Date (yyyy/mm/dd)

If the insured person is **under age 18** (Quebec) or **under age 16** (provinces or territories 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 or territories other than Quebec)

First and last names of the person signing for the insured person (please print)

X Signature

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 B** of this document.

X Signature of irrevocable beneficiary

Date (yyyy/mm/dd)

X Signature of creditor who holds a guarantee on the contract

X Signature of irrevocable beneficiary

Date (yyyy/mm/dd)

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N – Representative information

To be completed only if the policyowner wants to add ADO to the contract or increase the deposit amount to more than the permitted annual deposit.

Representative's first and last names (please print)	Representative code	Field office code

Email

X ______________________________
Signature of representative ☐ check if trainee

____
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)