



APPLICATION

ISSUE

CHANGES

REQUIRING EVIDENCE OF INSURABILITY



™ Trademark owned by Desjardins Financial Security Life Assurance Company

Contract no.									

1: GENERAL INFORMATION - Please print

A- Insured				B- Spouse - Complete only if coverage is requested for spouse			
Last name		First name		Last name		First name	
Initials		Initials		Initials		Initials	
Sex <input type="checkbox"/> M <input type="checkbox"/> F	Social insurance number	Date of birth DD MM YY	<input type="checkbox"/> Smoker <input type="checkbox"/> Non-smoker	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Social insurance number	Date of birth DD MM YY	<input type="checkbox"/> Smoker <input type="checkbox"/> Non-smoker
Place of birth (province or country)		If in Canada less than 2 years, in Canada since DD MM YY		Place of birth (province or country)		If in Canada less than 2 years, in Canada since DD MM YY	
Address				Address			
Postal code	Telephone Res. () Bus. ()			Postal code	Telephone Res. () Bus. ()		
Are you covered by: • Employment Insurance <input type="checkbox"/> Yes <input type="checkbox"/> No • a provincial health insurance plan <input type="checkbox"/> Yes <input type="checkbox"/> No • WCB/WSIB <input type="checkbox"/> Yes <input type="checkbox"/> No				Date of marriage or cohabitation DD MM YY		Occupation	
Please explain each "NO":				Are you covered under a provincial health insurance plan? <input type="checkbox"/> Yes <input type="checkbox"/> No - If not, please explain:			

2: INSURED'S BENEFICIARIES

First name	Last name	Relationship	Percentage	<input type="checkbox"/> revocable <input type="checkbox"/> irrevocable
INSURED				<input type="checkbox"/> revocable <input type="checkbox"/> irrevocable
INSURED				<input type="checkbox"/> revocable <input type="checkbox"/> irrevocable
SPOUSE				<input type="checkbox"/> revocable <input type="checkbox"/> irrevocable
SPOUSE				<input type="checkbox"/> revocable <input type="checkbox"/> irrevocable

3: INSURANCE IN FORCE none

Company name	Contract number	Issue date	Amount of coverage	Life coverage to be replaced by this application	
				Yes*	No
INSURED		DD MM YY		<input type="checkbox"/>	<input type="checkbox"/>
INSURED		DD MM YY		<input type="checkbox"/>	<input type="checkbox"/>
SPOUSE		DD MM YY		<input type="checkbox"/>	<input type="checkbox"/>
SPOUSE		DD MM YY		<input type="checkbox"/>	<input type="checkbox"/>

* Representative to complete the life insurance disclosure form.

4: POLICYOWNER

<input type="checkbox"/> Insured	<input type="checkbox"/> Employer
<input type="checkbox"/> Other - name and address	
Tel.: ()	

5: INSURED'S JOB CHARACTERISTICS Salaried employee Self-employed Unemployed

Occupation		Level of education	Field of study
Number of months worked per year	Number of hours worked per week	Employed since DD MM YY	Gross annual income Since what date? DD MM YY

Division of tasks

Office work %	Super-vision %	Sales %	Physical or manual labour %	Driving a vehicle %	Other, (specify) %
Employer				Nature of business	
Address				Telephone ()	
Postal code				Fax ()	

IF SELF-EMPLOYED and applying for Disability Insurance:

Self-employed workers must provide proof of income, such as most recent income tax statement, pay stub or employment contract. If operations began less than one year ago, please enclose a copy of the statement of income.

<input type="checkbox"/> Sole proprietor	<input type="checkbox"/> Stock company	<input type="checkbox"/> Partnership	Interest %	Number of full-time employees	Incorporation date of company DD MM YY	Number of years as owner
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11: DECLARATION AND AUTHORIZATION WITH RESPECT TO THE COLLECTION AND COMMUNICATION OF PERSONAL INFORMATION TO THIRD PARTIES

For the purpose of determining insurability, managing my file and processing claims, I hereby authorize any person, corporate body, public or parapublic organization holding personal information regarding myself and my health condition, medical history, or my eligibility for benefits, including any physician, dentist or other practitioner, hospital, medical or paramedical clinic, insurance or reinsurance company, the Medical Information Bureau, personal information agents, market intermediaries, any financial institution, the policyowner, my employer or ex-employer, WCB/WSIB, the Canada Pension Plan, the government plan requiring or providing automobile insurance benefits on a no-fault basis, the provincial health insurance plan to communicate the said information to Desjardins Financial Security Life Assurance Company (hereinafter referred to as Desjardins Financial Security) or its reinsurers upon request.

I also authorize Imperial Life to communicate the said information to the said third parties as well as to its reinsurers. For the same purpose and for the collection of the same type of information, I also authorize Imperial Life or its reinsurers to request an investigative report regarding myself and to use any information contained in other files, the object of which is accomplished.

This authorization applies also to the collection, use and communication of personal information regarding my minor children. Modifications or alterations to this authorization will have no impact on its content nor bind the insurer. In the event that this authorization is revoked, the insurance will automatically terminate. I hereby authorize Desjardins Financial Security to use or communicate my social insurance number for income tax and administrative purposes. A photocopy of this authorization is as valid as the original.

I hereby certify that the answers given above are accurate, complete and true. I agree that they form an integral part of my application for insurance. I hereby acknowledge that I have read the notice regarding the establishment of a personal information file, as well as the notice regarding the Medical Information Bureau and that I have received a copy thereof. **The insurance will become effective on the date that the evidence of insurability is approved by Desjardins Financial Security.** Any false declaration may result in the cancellation of the insurance. If for medical reasons my application for insurance is not approved as submitted, I authorize the medical director to provide the Company's reason for this decision to my physician.

Name and address of physician

Signature of insured

Signature of spouse

Signature of witness

Date

Signature of dependent children aged 16 and over to be insured

12: POLICYOWNER'S DECLARATION

I declare that the information contained in this application is complete and true, and agree that it is an integral part of the application for insurance. The insurance will become effective on the date the evidence of insurability is approved by Desjardins Financial Security Life Assurance Company, or on a later date as requested by the policyowner if this date is approved by the insurer.

Signature of policyowner if different from insured

Date

13: REPRESENTATIVE'S DECLARATION

I hereby certify that I have asked the individuals concerned all the questions on this application, and have entered their answers. I certify that, to the best of my knowledge, the answers are complete and true.

Representative's Name () Telephone Code Field office name Code

E-mail address () Fax No.

Signature of representative Date

If another insurance application has been submitted or being currently reviewed with this application, please provide the names and birth dates of the applicants.

Name Date of birth



Desjardins Financial Security™
life, health, retirement

NOTICE REGARDING THE CREATION OF A PERSONAL INFORMATION FILE

The personal information that Desjardins Financial Security holds or will hold regarding you is treated confidentially and will be kept in a file for the purpose of enabling you to benefit from the various financial, annuity, credit and other services that the company offers. The information will be consulted only by the personnel at Desjardins Financial Security Life Assurance Company (hereinafter referred to as Desjardins Financial Security) who must do so in order to exercise their functions.

You may access your file and rectify the information therein if you are able to show that the information is incorrect, incomplete, ambiguous, obsolete or unnecessary. If you wish to consult your file, you must send a written request to the attention of the person in charge of access to information at the company's head office: Desjardins Financial Security, 95 St. Clair Avenue West, Toronto ON M4V 1N7.

NOTICE REGARDING THE MEDICAL INFORMATION BUREAU

The information regarding your insurability is treated confidentially. However, Desjardins Financial Security or its reinsurers may provide a summary of this information to the Medical Information Bureau, a non-profit organization created by life insurance companies for the exchange of information between member companies. If you enrol in life or health insurance with a company that is a member of the Bureau, or if you file a claim for benefits or indemnities, upon request the Bureau will provide the company with the information it holds regarding you.

Upon receipt of a request from you, the Bureau will disclose the information contained in your file. If you question the accuracy of the Bureau's information, you may ask that the information be rectified by writing to the Medical Information Bureau at 330 University Avenue, Toronto, Ontario M5G 1R7. The telephone number is: (416) 597-0590.

NOTICE REGARDING THE EFFECTIVE DATE OF THE POLICY

Please be advised that the insurance will become effective on the date that the evidence of insurability is approved by Desjardins Financial Security.

Representative Telephone: Bus. () Res. ()

The Policyowner understands that the Representative is paid by commission.

