Desjardins
Insurance
LIFE • HEALTH • RETIREMENT

GROUP INSURANCE - DISABILITY CLAIMS

DIRECT DEPOSIT - ENROLMENT OR CHANGES

DISABILITY CLAIMS

Last name and first name of the member	Certificate or identification no.
Address - No., street, apartment	Policy or group or contract no.
City	Telephone no. ( ) -
Province / Postal code	

I hereby authorize Desjardins Financial Security Life Assurance Company, hereinafter Desjardins Insurance, to deposit my benefit payment through the DIRECT DEPOSIT system into account at the financial institution indicated below:

Name of financial institution: _____

Address: _____

Institution no.: _____ **Transit/Branch no.:** _____ **Account no.:** _____

Please include a specimen cheque marked "VOID".

Any credit entered in my account in accordance with this authorization will be identified with a DIRECT DEPOSIT transaction code and I acknowledge that the credit in question shall constitute an amount paid in accordance with this authorization.

This authorization will be effective on _____ . The authorization will terminate following a 10-day written notice by either Desjardins Insurance or me.

Signature of member _____ **Date** _____

Please return to: **Desjardins Insurance**
C. P. 3875 succ. Lévis
Lévis (Québec) G6V 0A7

or by fax: 418-835-0194
1-844-409-6575