Desjardins Insurance
LIFE • HEALTH • RETIREMENT

GROUP INSURANCE

C. P. 3000
Lévis (Québec) G6V 9X8

Evidence of insurability

Attach, if applicable, a copy of the insurance application when submitting this form.

Dental care

ACCOUNT NUMBER

Name and address of participant		Name and address of employer	
Mandatory			
	Postal code		Postal code
Certificate number	Identification number	Occupation	Telephone number: Home: area code + number Work: area code + number

	NAME	DATE OF BIRTH		NAME	DATE OF BIRTH
PARTICIPANT			CHILDREN		
SPOUSE					

Are any of the proposed insureds:	PARTICIPANT YES	PARTICIPANT NO	SPOUSE YES	SPOUSE NO	CHILDREN YES	CHILDREN NO
1. currently receiving dental care?	☐	☐	☐	☐	☐	☐
2. expecting to receive dental care in the next 12 months?	☐	☐	☐	☐	☐	☐
3. currently suffering from a disease of the mouth, jaw or gums?	☐	☐	☐	☐	☐	☐
4. have ever suffered from a disease of the mouth, jaw or gums?	☐	☐	☐	☐	☐	☐

FOR EACH "YES", PLEASE PROVIDE THE INFORMATION REQUIRED BELOW.

	PARTICIPANT	SPOUSE	CHILDREN	
Annual check-up including cleaning and x-rays	☐Yes ☐No Date	☐Yes ☐No Date	☐Yes ☐No First name Date	☐Yes ☐No First name Date
Extractions If yes, how many?	☐Yes ☐No How many? ____ Date	☐Yes ☐No How many? ____ Date	☐Yes ☐No How many? ____ First name Date	☐Yes ☐No How many? ____ First name Date
Fillings If yes, how many?	☐Yes ☐No How many? ____ Date	☐Yes ☐No How many? ____ Date	☐Yes ☐No How many? ____ First name Date	☐Yes ☐No How many? ____ First name Date
Orthodontic services	☐Yes ☐No How many? ____ Date	☐Yes ☐No How many? ____ Date	☐Yes ☐No How many? ____ First name Date	☐Yes ☐No How many? ____ First name Date

PLEASE FILL OUT REVERSE SIDE

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	PARTICIPANT	SPOUSE	CHILDREN	
Any other treatment If yes, please specify	☐ Yes ☐ No Date	☐ Yes ☐ No Date	☐ Yes ☐ No First name Date	☐ Yes ☐ No First name Date
Please provide details for any affirmative answer to question 2, including: diagnosis, treatment, duration, result.			First name	First name

PERSONAL INFORMATION MANAGEMENT

Desjardins Financial Security Life Assurance Company (DFS) handles the personal information it has on you in a confidential manner. DFS keeps this information on file so that you may benefit from the Company's various financial services (insurance, annuities, credit, etc.). This information is consulted solely by DFS 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 Financial Security Life Assurance Company, 200, rue des Commandeurs, Lévis, Québec, G6V 6R2.

DFS may use the client list to offer its clients an insurance product following the termination of their group insurance. If you do not wish to receive these offers, you may have your name removed from the list. To do so, you must send a written request to the Privacy Officer at DFS.

DFS uses service providers located outside of Canada to perform certain specific activities in its normal course of business. As such, it is possible that some of your personal information may be transferred to another country and be subject to the laws of that country. For information about DFS's policies and practices in terms of transferring personal information outside of Canada, visit the DFS website at www.dsf-dfs.com, or write to the DFS Privacy Officer at the address indicated above. The Privacy Officer can also answer any questions you may have about the transfer of personal information to service providers located outside of Canada.

NOTICE APPLICABLE TO MIB, INC.

Information regarding the insurability of the person to be insured will be treated as confidential by Desjardins Financial Security Life Assurance Company (DFS), its reinsurers and MIB, Inc., a non-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, Inc. member company, upon request, MIB, Inc. will supply such company with the information it has on file about this person. MIB, Inc. 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, Inc. has agreed to protect such information in a manner that is substantially similar to DFS's privacy and personal information protection practices and in accordance with applicable laws. As a U.S.-based company, MIB, Inc. is also bound by U.S. laws regarding the disclosure of personal information. If you have any questions about MIB, Inc.'s commitment to ensuring the confidentiality of insureds' personal information, contact the MIB, Inc. Privacy Department at privacy@mib.com. Upon request, MIB, Inc. will disclose all of the information in an insured's file to that insured. Insureds can contact MIB, Inc. at 416 597-0590. Insureds who dispute the accuracy of the information MIB, Inc. has on record for them can seek a correction in accordance with the procedures set forth on MIB, Inc.'s Website at www.mib.com. They can also write to MIB, Inc.'s information office at 330 University Avenue, Suite 501, Toronto, Ontario M5G 1R7. DFS 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, Inc. at www.mib.com.

DECLARATION AND AUTHORIZATION TO COLLECT AND COMMUNICATE PERSONAL INFORMATION

For the sole purpose of determining insurability, managing files and processing claims, I authorize Desjardins Financial Security Life Assurance Company (DFS) or its reinsurers: a) 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 health care professional or establishment, MIB, Inc., insurance and reinsurance companies, personal information brokers, investigation firms, the contract holder, my employer or my former employers; b) 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; c) 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; d) to disclose to my personal physician any medical information about me that was obtained during the evaluation of my file; e) to disclose to other insurers or reinsurers any information about me that is relevant to determining my eligibility for insurance or for benefits; f) to provide a brief report of my personal health information to MIB, Inc. This authorization also applies to the collection, use and communication of personal information regarding my dependents, insofar as applicable to my claim. A photocopy of this authorization is as valid as the original. I hereby certify that the answers given above are complete and true. I agree that they form an integral part of my application for insurance. I hereby acknowledge that I have read the Personal Information Management section, as well as the notice regarding the MIB, Inc. and that I have received a copy thereof. The insurance will become effective on the date indicated on the contract. Any false declaration may result in the cancellation of the insurance. If for medical reasons my application for insurance is not accepted as it was submitted, I authorize the medical director to provide the reason for such a decision to my physician.

Name and address of physician _____

Signature of participant	Signature of spouse	Signature of witness	Date

Signature of dependent children aged 16 and over to be insured (aged 14 and over for Québec) _____

AUTHORIZATION TO COLLECT AND COMMUNICATE PERSONAL INFORMATION

For the sole purpose of determining insurability, managing files and processing claims, I authorize Desjardins Financial Security Life Assurance Company (DFS) or its reinsurers: a) 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 health care professional or establishment, MIB, Inc., insurance and reinsurance companies, personal information brokers, investigation firms, the contract holder, my employer or my former employers; b) 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; c) 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; d) to disclose to my personal physician any medical information about me that was obtained during the evaluation of my file; e) to disclose to other insurers or reinsurers any information about me that is relevant to determining my eligibility for insurance or for benefits; f) to provide a brief report of my personal health information to MIB, Inc. This authorization also applies to the collection, use and communication of personal information regarding my dependents, insofar as applicable to my claim. A photocopy of this authorization is as valid as the original.

Signature of participant	Signature of spouse	Signature of witness	Date

Signature of dependent children aged 16 and over to be insured (aged 14 and over for Québec) _____

THE PARTICIPANT MUST RETURN THE ORIGINAL TO DESJARDINS FINANCIAL SECURITY LIFE ASSURANCE COMPANY ALONG WITH HIS APPLICATION AND KEEP A COPY FOR HIS RECORDS.