Desjardins Financial Security®

200, rue des Commandeurs
Lévis (Québec) G6V 6R2

GROUP INSURANCE - CONTRACT ADMINISTRATION

APPLICATION FOR ENROLMENT

A group benefits plan insured by Desjardins Financial Security and administered by: CBIA | AABC

Please check one: ☐ **New Application** ☐ **Reinstatement**

A - IDENTIFICATION – Please print

Last Name	First Name	Date of Birth (YYYY MM DD)	Sex
			☐ M ☐ F

Marital Status		Province of Residence	Language
☐ Single ☐ Common-Law ☐ Married ☐ Civil Union (Québec only)	(Common-law spouse is eligible for benefits after 12 months of cohabitation)		☐ English ☐ French

Occupation	Employed by

Number of Hours Worked by Week	Annual Earnings	Employment Date or Reinstatement Date (YYYY MM DD)	Effective Date of Coverage (YYYY MM DD)	Insurance Coverage
				☐ Individual ☐ Family

Do you have individual CBIA disability coverage? ☐ Yes ☐ No

If Yes, do you want to integrate benefits? ☐ Yes ☐ No If Yes, complete integration election form.

If allowed under my plan, I elect not to participate in the:

☐ Health Care Plan ☐ Dental Plan because of spousal coverage **Please complete Part B on reverse side.**

B - DESIGNATION OF BENEFICIARY(IES) – See below for information on beneficiary designation

Last name, first name	Date of birth if minor (YYYY MM DD)	Relationship	%	Please check
				☐ Revocable ☐ Irrevocable
				☐ Revocable ☐ Irrevocable
				☐ Revocable ☐ Irrevocable
				☐ Revocable ☐ Irrevocable

DESIGNATION OF A TRUSTEE **(Important information below)**

For the province of Québec: The provisions of the Civil Code apply. DO NOT complete this section.
For all other provinces: Complete this section only if you have named a minor beneficiary.

Last and first names of trustee _____ Relationship _____

Address of trustee _____
No., street City Province Postal code

DESIGNATION OF BENEFICIARY(IES)

For all other provinces except Québec: This designation of beneficiary is REVOCABLE unless otherwise stipulated.

For the province of Québec: Unless otherwise stipulated, the designation of a legal spouse or spouses joined in a civil union as beneficiary is IRREVOCABLE. Unless otherwise stipulated, the designation of any other person as beneficiary is REVOCABLE.

REVOCABLE: means that the designation of beneficiary can be changed without the beneficiary's consent.

IRREVOCABLE: means that the signature of the irrevocable beneficiary is mandatory to change the beneficiary. The IRREVOCABLE designation of a minor cannot be changed until he or she reaches the majority.

DESIGNATION OF A TRUSTEE - Does not apply in Québec

A minor beneficiary cannot discharge a payment to a payer. Consequently, the trustee designated above will receive in trust for a minor beneficiary any amount under the plan established by Desjardins Financial Security. Receipt of these funds by the trustee constitutes a discharge for Desjardins Financial Security. A designation is valid until a new trustee is named or until the beneficiary will have reached the age of majority, whichever occurs first.

C - DECLARATION AND AUTHORIZATION FOR THE COLLECTION AND COMMUNICATION OF PERSONAL INFORMATION

I certify that all information provided herein is complete and true. I acknowledge that all the benefits offered in the contract are subject to the provisions for limitations or reductions as well as to the exclusions stipulated therein. I acknowledge that I have read and received a copy of the Personal Information Management section at the back of this form. In the event of death, I expressly authorize my beneficiary(ies), heir(s) or estate liquidator(s) to provide Desjardins Financial Security or its reinsurers with all the information or authorizations deemed necessary to study the claim and obtain the required proofs. This authorization also applies to my minor children, insofar as applicable to this claim. I hereby apply for insurance coverage in accordance with the provisions and conditions of the Bar Group Insurance Contract. I authorize the deduction from my earnings of any required contribution for the insurance to which I am or may be entitled. A photocopy of this authorization is as valid as the original.

Signature of member **Date**

Please give a copy to the member

PLEASE SEE REVERSE SIDE

® Registered trademark owned by Desjardins Financial Security

Purpose of the Application for Group Insurance

The purpose of the application for group insurance is to provide written confirmation of your wish to obtain coverage under the group insurance policy held by the policyholder. The information requested will be used to determine your coverage and your premium.

Note

If your application is received more than 31 days after expiry of your eligibility period or if the amount of the life insurance, weekly indemnity and/or long term disability benefit is greater than the maximum amount permitted without evidence of insurability, your application must be accompanied by the form **Evidence of Insurability**, form **G12**.

For further information, please refer to the contract.

Instructions - Please complete and sign below:

PART A, if applying for **Family** coverage.
PART B, if you are electing not to enrol in any or all coverages.
PART C, if your firm is applying for the Dependent Life Benefit and you are applying for **Individual** coverage and have no dependents.

PART A – INFORMATION ON DEPENDENTS – Complete if you selected family coverage

Last name, first name	Sex M - F	Relationship with member (spouse, child)	Date of birth YYYY	MM	DD	Dependent's status S = 21 to 25 years, full-time student X = Functional impairment	Covered under another plan Health Yes / No	Dental Yes / No

PART B – GROUP WAIVER COVERAGE – To be completed by the employee and employer whenever the employee elects not to enrol in any or all coverages

I hereby acknowledge that all the benefits available to me have been fully explained to me and that I understand them.

I further acknowledge that I am forfeiting (as indicated below) all of my rights and privileges in respect to such benefits. I understand that a medical examination at my own expense may be required if I choose to apply for such benefits at some later date for myself (and any dependents).

☐ I waive total coverage for myself and dependents, if any.
☐ I waive Extended Health Plan Coverage and Dental Coverage.
☐ I waive Extended Health Plan Coverage.
☐ I waive Dental Coverage.

Reason for Declining Coverage (Check One)

☐ Covered by Spousal Coverage ☐ Other - specify _____

PART C – WAIVER OF DEPENDENT LIFE COVERAGE

☐ I am applying for **Individual** coverage, have no dependents and wish to opt out participation in the Dependent Life Benefit.

PART D – SIGNATURES

_____ _____
Signature of member **Date**

_____ _____
Signature of employer **Title of employer**

PERSONAL INFORMATION MANAGEMENT

Desjardins Financial Security (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 group insurance services offered by the Company. 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, 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.