Desjardins Insurance
Life • Health • Retirement

C. P. 3000
Lévis (Québec) G6V 9X8
1-877-647-5235
desjardinslifeinsurance.com/planmember

FINANCIAL SERVICES INCLUDING INSURANCE, ANNUITIES, CREDIT AND RELATED SERVICES

INSURANCE CONTRACT ADMINISTRATION

INDIVIDUAL HEALTH INSURANCE APPLICATION

Health Track Insurance®

POLICY NO. E888

☐ **ENROLLMENT**

☐ **CHANGE**

For Quebec residents only
Once we receive your enrollment forms, a Desjardins Insurance advisor will contact you as required by the provincial law.

A – IDENTIFICATION OF POLICYHOLDER

Please print.

Last name	First name	Health Track certificate number (for changes only)

Address – No., street, apt.	City	Province	Postal code

Telephone number	Email	Date of birth (YYYY MM DD)	Sex	Language
			☐ M ☐ F	☐ E ☐ F

Former employer	Former contract number	Certificate or identification No. used in the former contract

Name of previous insurer	Group coverage ended on (YYYY MM DD)	Coverage held with previous insurer
		☐ Individual ☐ Family ☐ Single-parent ☐ Couple

IMPORTANT – If Desjardins Insurance[1] was not your previous insurer, please submit evidence of your previous coverage and its end date.

1. Did you have extended healthcare coverage under your group insurance plan?	☐ Yes	☐ No
2. Did you have dental care coverage under your group insurance plan?	☐ Yes	☐ No
3. Were you actively at work when your group coverage ended?	☐ Yes	☐ No
4. Do you want to receive your insurance policy and related documents by email?	☐ Yes	☐ No

B – OPTION AND COVERAGE SELECTION

OPTION CHANGE RULES

- You may increase your coverage at any time by selecting an option with more comprehensive benefits than what you already have.
- You must keep the same option for 36 months before you can reduce your coverage or as a result of a life event.
- You must keep the optional dental care benefit for 36 months before you can cancel it.

COVERAGE SELECTION RULES

- If you were enrolled in family, single-parent or couple coverage under your group insurance plan, you may choose either the coverage without dependents (individual) or the coverage with dependents (family).
- If you were enrolled in individual coverage under your group insurance plan, you can only choose coverage without dependents (individual).

OPTION SELECTION	Check only one option: ☐ BRONZE OPTION ☐ SILVER OPTION ☐ GOLD OPTION*	* If you have selected the GOLD option, please read the information below and indicate your choice: I want to enroll in the Optional dental care benefit: ☐ Yes ☐ No **In order to be eligible for the optional dental care benefit, you must have answered "Yes" to question 2 in section A of this form. You can only enroll in the optional dental care benefit when you enroll in Health Track Insurance. It is not possible to enroll in this benefit at a later date.**
COVERAGE SELECTION	Check only one coverage:	☐ Coverage without dependents (individual) ☐ Coverage with dependents (family)

C – IDENTIFICATION OF DEPENDENTS

To be filled out if you select the coverage with dependents. Please see the guidelines that apply if you select this coverage in section B.

				Status of dependent: Full-time student (aged 21 to 25 inclusive) or has a functional impairment	
Last name and first name	**Relation**	**Sex**	**Date of birth**	**Full-time student or has a functional impairment**	**Name of educational institution**
	☐ Spouse ☐ Child	☐ M ☐ F	YYYY MM DD	☐ F. time student YYYY MM DD ☐ Funct. imp. YYYY MM DD From To	
	☐ Spouse ☐ Child	☐ M ☐ F	YYYY MM DD	☐ F. time student YYYY MM DD ☐ Funct. imp. YYYY MM DD From To	
	☐ Spouse ☐ Child	☐ M ☐ F	YYYY MM DD	☐ F. time student YYYY MM DD ☐ Funct. imp. YYYY MM DD From To	

1. Desjardins Insurance refers to Desjardins Financial Security Life Assurance Company (DFS).

Print | New request

Continued on the back. Don't forget to sign section E.

DOCUMENTS SENT ON: YYYY MM DD

D – PAYMENT METHOD

Select one payment method only and complete the related section (1 or 2).

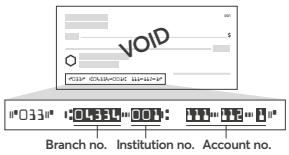
☐ **1. AUTHORIZATION FOR DEDUCTION AT SOURCE** | Please provide your social insurance number:

I authorize any entity authorized by Desjardins Insurance, such as Retraite Québec, to deduct at the source of payment, namely from my pension benefits, the premium amount, until further notice. I authorize Desjardins Insurance to use or communicate my social insurance number for administrative purposes.

Signature of policyholder **Date**

☐ **2. PERSONAL PRE-AUTHORIZED DEBIT ENROLLMENT (PAD) – PAYOR AUTHORIZATION**

- **Attach a personal cheque marked ''VOID'' to avoid errors in transcription.**
- **If you change your account or financial institution, please advise Desjardins Insurance.**



Last and first name(s) of account holder(s)		Telephone No.	
Name of the financial institution where the account is located	Transit/branch No.	Institution No.	Account No.

WITHDRAWAL AUTHORIZATION

I authorize Desjardins Insurance to make monthly pre-authorized debits (PAD) from my account with the aforementioned financial institution. Each withdrawal will correspond to a variable amount. I will receive pre-notification of this variable amount from Desjardins Insurance no later than the date the premium is scheduled to be withdrawn. **Consequently, I hereby waive my right to be sent this pre-notification within the 10-day period set out under Payments Canada's Rule H1. I further waive my right to receive any pre-notification as long as the withdrawal amount remains the same or when changes are made to my personal coverage at my request.** I hereby acknowledge having received a copy of this Agreement.

CHANGE OR CANCELLATION

I shall inform Desjardins Insurance in a timely manner, of any changes to this Agreement. I retain the right to revoke my authorization at any time, with a pre-notification of 30 calendar days. To obtain a sample of the cancellation form or for more information on my right to cancel a PAD Agreement, I may contact my financial institution or visit Payments Canada Web site at payments.ca. I agree to release the financial institution of any liability if the revocation is not respected, except in the case of gross negligence on its part. I agree that the financial institution at which I maintain the account is not required to verify that the payment is debited in accordance with this authorization. I also certify that every person whose signature is required for the operation of the aforementioned account has signed this authorization. I acknowledge that the delivery of this authorization to Desjardins Insurances constitutes delivery by me to the aforementioned financial institution.

REIMBURSEMENT

I have certain recourse rights if any debit does not comply with this Agreement. For example, I have the right to receive reimbursement for any debit that is not authorized or is not consistent with this PAD Agreement. To obtain more information on my recourse rights, I may contact my financial institution or visit payments.ca. The financial institution shall reimburse me, on behalf of the organization, for any amounts withdrawn in error, within 90 calendar days of the withdrawal, provided that the reimbursement is claimed for a valid reason. I understand that a claim to this effect must be made to my financial institution following the procedure it will provide for that purpose. Finally, I acknowledge that a claim for reimbursement filed after the aforementioned time limits must be settled between me and Desjardins Insurance, without any liability or commitment on the part of my financial institution.

CONSENT TO DISCLOSURE OF INFORMATION

I hereby consent to the disclosure of the information contained in my pre-authorized debit enrollment agreement to the financial institution, provided such information is directly related to and required for the smooth application of the rules governing pre-authorized debits.

Signature of account holder **Date**

Signature of a second account holder (only if two signatures are required) **Date**

E – DECLARATION AND AUTHORIZATION FOR THE COLLECTION, USE AND COMMUNICATION OF PERSONAL INFORMATION

I certify that all the information provided herein is complete and true. I acknowledge having read the comparative table, the rate leaflet, the Take the next step with Health Track Insurance brochure and am aware of the options available to me. I acknowledge that all the benefits offered in the policy are subject to the provisions for limitations or reductions as well as to the exclusions stipulated therein.

I authorize Desjardins Insurance, its agents and service providers to collect, use and disclose information about me, my spouse or my dependents to any person or organization including the pharmacies, healthcare practitioners, institutions, investigative agencies or insurers for the purposes of underwriting, administration, optimal health management (management claim tools, informative health documentations etc.), auditing and paying claims. To achieve the purposes described above and to provide you support, your information, on a depersonalized basis, may be used for analysis, statistics and development of predictive models.

My policy will be sent to me once the insurer has received my individual health insurance application. I understand that I will have 10 days from the date I receive the policy to cancel it.

I acknowledge and accept that this consent takes precedence over any other consent I have previously signed. This consent remains in effect for as long as I maintain a business relationship with Desjardins Group.

By signing this form, I authorize Desjardins Insurance to collect, use and disclose my personal information in accordance with privacy regulations and Desjardins Group's Privacy Policy that was presented to me before signing this consent.

I acknowledge having read the information appearing on this form and have kept a copy of the form. A photocopy of this authorization is as valid as the original.

For Quebec residents: I understand that the French-language documents for Health Track Insurance are available at desjardinsassurancevie.com/adherent. However, I expressly request to enter into this policy in English. I also expressly request that the documents related to this policy be written exclusively in English. I understand that I can ask at any time to receive my documents in French.

Signature of policyholder **Date**

PERSONAL INFORMATION MANAGEMENT

To serve you effectively every day and fulfill our legal obligations, we need to collect, use and disclose information about you. You can read Desjardins Group's Privacy Policy at www.desjardins.com/privacy-policy for full details on how your personal information is processed. Specific consents may be required to begin and maintain a business relationship with Desjardins Insurance. These steps will be taken in compliance with Desjardins Group's Privacy Policy. Desjardins Insurance handles your personal information in a confidential manner. Access to your file is limited to authorized personnel who need it to access it to perform their duties. You have the right to review your personal information in our files and correct anything that is incomplete, ambiguous or not relevant. To do so, please consult our Privacy Policy.

Please send us the form using one of the options below:

Online	By mail	By fax
desjardinslifeinsurance.com/send	Desjardins Insurance C. P. 3000, Lévis (Québec) G6V 9X8	418-833-7051 or 1-866-833-7051

Keep a copy for your records.