Desjardins Insurance
Life • Health • Retirement

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APPLICATION FOR ENROLLMENT OR REQUEST FOR CHANGE

GROUP INSURANCE PLAN FOR UNIONIZABLE BUT NOT UNIONIZED AND NON-UNIONIZABLE EMPLOYEES OF QUEBEC'S HEALTH AND SOCIAL SERVICES SECTOR – C001

I want to: ☐ **enroll in the group insurance plan** ☐ **modify my group insurance plan**

Section A. Identification of employer (please print)

Name of employer	Group number	Division number
	C001	

Section B. Identification of plan member

Last name of plan member	First name	Identification or certificate number

Address – No., street, apt.	Date of birth (YYYY MM DD)	Sex	Language
		☐ M ☐ F	☐ English ☐ French

City	Province	Postal code

Employment status	I work:	Annual salary	Service or hire date (YYYY MM DD)	Employee number
☐ Permanent ☐ Temporary	☐ full-time (more than 70%) ☐ part-time (26% to 70%) ☐ part-time (25% or less)			

Previous employer	Division number	Date of termination of employment (YYYY MM DD)

Section C. Choice of module and coverage type (the **coverage type must be the same** for health insurance and dental care insurance.)

Benefits	Choice of module	Coverage type	Contract provisions
Healthcare insurance	☐ Basic ☐ Intermediate ☐ Complete	☐ Individual ☐ Couple ☐ Single-parent ☐ Family ☐ Exemption	Participation in the health insurance benefit is mandatory. However, you may request an exemption if you already have comparable coverage. The minimum participation period in the selected health insurance module is 24 months before you may switch to a lower module. You may, however, increase your level of protection at any time.
Dental care (optional benefit)	☐ Basic ☐ Complete ☐ I do not wish to enroll	This section must be completed only if the health insurance exemption option has been selected ☐ Individual ☐ Couple ☐ Single-parent ☐ Family	Participation in dental care plan is optional. The minimum participation period in the dental insurance plan is 36 months before you may switch to a lower module or end your participation. You may, however, join the plan or increase your level of coverage at any time. **Note that an exemption from health insurance allows you to participate in the dental insurance plan under the coverage status that suits your needs.**
Long-term disability insurance	☐ I wish to decline long-term disability insurance.*		Participation in this benefit is mandatory, and issubject to the right to opt-out of long-term disability insurance. * You must complete the Opt-out of Long-Term Disability Insurance form (22045E) to exercise this right.
Basic life insurance and accidental death and dismemberment			Mandatory coverages according to the provisions: Plan member: 1x annual salary Spouse: $10 000 Children: $5 000
Optional benefits[1] Additional plan member's life insurance and accidental death and dismemberment	I wish to enroll : ☐ Yes ☐ No Multiples of annual salary : ☐ 1x ☐ 2x ☐ 3x ☐ 4x ☐ 5x		You must complete the Evidence of Insurability form (20009A). It must be received by the insurer within 45 days of your application. Otherwise, your application will automatically be cancelled and you will have to resubmit it.

[1]Québec residents only: Under provincial law, you have 10 days to cancel optional benefits.

For full terms and conditions, please see the Notice of Cancellation form (19210E) at desjardins.com/planmember.

Section D. Changes (check the desired module and coverage type in section C)

Indicate the life event that justifies the requested change in **coverage status**:

- ☐ Death
- ☐ Divorce, separation or end of cohabitation
- ☐ Children no longer dependent
- ☐ Spouse eligible for new insurance coverage
- ☐ Marriage or civil union
- ☐ Common-law union (at least 12 months)
- ☐ Termination of spouse's insurance
- ☐ Birth, adoption or legal custody of a child
- ☐ Child's return to school
- ☐ No life event

Life event date

YYYY MM DD

Section E. Designation of beneficiaries

Revocable beneficiary: The designation of beneficiary or contingent beneficiary can be changed without the beneficiary's consent.

Irrevocable beneficiary: The signature of the irrevocable beneficiary or contingent beneficiary is mandatory to change the beneficiary. The IRREVOCABLE designation of a minor cannot be changed until they reach the age of majority.

PROVINCE OF QUÉBEC

- The designation of a legally married or civil-union spouse as beneficiary or contingent beneficiary is IRREVOCABLE, unless otherwise stipulated below:

☐ **Revocable designation – I may change this beneficiary designation at any time.**

- The designation of any other person as beneficiary or contingent beneficiary is REVOCABLE. If you want to make their designations irrevocable, use the Request for Designation or Change of Beneficiaries, Contingent Beneficiaries or Trustee form (20007A).

ALL OTHER PROVINCES

- The designation of all beneficiaries or contingent beneficiaries is REVOCABLE. If you want to make their designations irrevocable, use the Request for Designation or Change of Beneficiaries, Contingent Beneficiaries or trustee form (20007A).

BENEFICIARIES

	Last name, first name	Relationship with plan member	%
1		☐ Common-law ☐ Spouse ☐ Child ☐ Friend ☐ Parent ☐ Other:	
2		☐ Common-law ☐ Spouse ☐ Child ☐ Friend ☐ Parent ☐ Other:	
3		☐ Common-law ☐ Spouse ☐ Child ☐ Friend ☐ Parent ☐ Other:	
4		☐ Common-law ☐ Spouse ☐ Child ☐ Friend ☐ Parent ☐ Other:	

CONTINGENT BENEFICIARIES: Designated persons who will receive the benefit if the primary beneficiaries are deceased at the time of payment.

	Last name, first name	Relationship with plan member	%
1		☐ Common-law ☐ Spouse ☐ Child ☐ Friend ☐ Parent ☐ Other:	
2		☐ Common-law ☐ Spouse ☐ Child ☐ Friend ☐ Parent ☐ Other:	

Section F. Designation of trustee – Does not apply in Québec: the provisions of the Civil Code apply. DO NOT complete this section.

All other provinces: Complete this section **only** if you have named a minor beneficiary.

The designated trustee will receive in trust for a minor beneficiary any amount under the plan established by Desjardins Financial Security Life Assurance Company, hereinafter Desjardins Insurance. Receipt of these funds by the trustee constitutes a discharge for Desjardins Insurance. A designation is valid until a new trustee is named or until the beneficiary reaches the age of majority, whichever occurs first.

Last name and first name of trustee _____

Section G. 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. Desjardins Insurance may use the client list to offer its clients an insurance product following the termination of their group insurance.

Section H. 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 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 the information on this form and that I have received a copy thereof. In the event of death, I expressly authorize my beneficiary(ies), heir(s) or estate liquidator(s) to provide Desjardins Insurance 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 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. I authorize my employer to deduct the required premium contributions from my salary. A photocopy of this authorization is as valid as the original.

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.

Signature of plan member _____ **Signature of employer's representative** _____ **Date** _____

PLAN ADMINISTERED THROUGH THE SECURE SITE FOR PLAN ADMINISTRATORS – Keep the original and give a copy to the plan member.

PLAN ADMINISTERED BY THE INSURER – Send the original to Desjardins Insurance and give a copy to the plan member.

PRINT NEW REQUEST