

Financial file: Insurance, pension, credit and related
 services

MEDICAL STUDENT – The student must be under age 35 and must be a full time student.

Have you interrupted your medical studies for a medical reason? By interruption, we understand a period of two consecutive sessions.

 No interruption

 One interruption : From : _____ To : _____

 More than one interruption : 1. From : _____ To : _____ 2. From : _____ To : _____

3. From : _____ To : _____

A) IDENTIFICATION

Name		First name		Date of birth YY / MM / DD	
Present address: number, street			Social insurance number (optional)		Gender <input type="checkbox"/> M <input type="checkbox"/> F
City and province		Postal code	Telephone number Home ()		Communication language <input type="checkbox"/> French <input type="checkbox"/> English
Years at university 1st year <input type="checkbox"/> 2nd year <input type="checkbox"/> Extern 1 <input type="checkbox"/> Extern 2 <input type="checkbox"/>			E-mail		
Date on which you will end your studies YY / MM / DD		University			

Please give name of relative to contact if you cannot be reached

Address – number, street		Telephone number Home ()	
City and province	Postal code	E-mail	

B) DISABILITY INSURANCE – This insurance is subject to the limitations and exclusions stipulated in ContractNo. B172
 I wish to take out disability insurance of \$_____ - waiting period 90 days.

I understand that my coverage will be increased in accordance with the dates and amounts set out in the contract, without evidence of insurability being required.

C) OTHER INSURANCE – If no other insurance, please check

Company	Amount	Replaced by this plan	
		Yes <input type="checkbox"/>	No <input type="checkbox"/>
		Yes <input type="checkbox"/>	No <input type="checkbox"/>

D) PREAUTHORIZED PAYMENTS

Please sign the authorization below and include a specimen cheque marked "VOID"

I hereby authorize Sogemec Assurances Inc. to make monthly withdrawals from the account shown on the attached specimen cheque. Withdrawals will be made on the first day of each month.

 Signature of account holder(s)

CERTIFICATION AND AUTHORIZATION FOR THE COLLECTION AND COMMUNICATION OF PERSONAL INFORMATION

I certify that the information contained in this insurance application is true and complete. I understand that the insurance offered is subject to the limitations, reductions and exclusions stipulated in the contract. I have read the information appearing on the back of this form and have received a copy of it. I authorize Desjardins Sécurité financière life insurance company to use or communicate my social insurance number for administrative purposes. A photocopy of this consent has the same value as the original.

Applicant's signature: _____ Date: _____

 Return this application to
Sogemec Assurances inc.
 2 Complexe Desjardins, Tour de l'est, 31st floor, PO Box 217 – Succursale Desjardins, Montreal. QC, H5B 1G9

 For more information, please contact us at :
 Telephone : (514) 350-5070 Other regions: 1 800 361-5303 Fax: (514) 350-5071

COVER NOTE

A member's insurance takes effect if he is pursuing his studies and carrying out his duties as a medical student or if he was one on the last day he should normally have been a student or, if he is not pursuing his studies, he can carry out the duties of a student as of the latest of the following dates:

- a) The date on which he became eligible;
- b) The date on which the administrator receives the membership application,
- c) the date on this evidence of insurability was accepted by the insurer, if applicable.

If the member is not actively pursuing his studies or cannot carry out his duties as a student because of illness or an accident on the day his insurance comes into effect, he shall become insured the day he returns to his studies and performs his duties as a student or, if he is not pursuing his studies, the day he shall be able to carry out fully his duties as a student.

The member must not be disabled at the time his insurance coverage is increased.

EVIDENCE OF INSURABILITY

The Plan is subject to evidence of insurability considered satisfactory by the insurer if the insurance application is received by the insurer after the date specified.

TRANSFER

The member can transfer his coverage within 180 days of obtaining his title of family physician or specialist in the FMSQ group insurance plan. Certain conditions apply. For more details, please refer to the contract.

TERMINATION OF INSURANCE

The Plan shall terminate no later than six (6) months after obtaining the title of family physician or specialist, without exceeding two (2) years following the end of residency. The member may terminate his coverage at any time.

MANAGEMENT OF PERSONAL INFORMATION

Desjardins Sécurité financière life insurance company (DSF) treats personal information concerning you in a confidential manner. DSF keeps such information in a file so that you may benefit from the various financial services (insurance, pensions, credit, etc.) that it provides. Such information is only consulted by employees of DSF who have need of it in the course of their work.

You are entitled to consult your file. You can also correct any information that you can show to be inaccurate, incomplete, ambiguous or needless. Should this occur, you should send a written request to the following address:

Personal Information Protection Agent
Desjardins Sécurité financière life insurance company
200 avenue des Commandeurs
Lévis, QC
G6V 6R2

For residents of all Canadian provinces, except British Columbia:

DSF can use its list of clients for the purpose of offering them an insurance product upon their retirement. If you do not wish to receive such an offer, you have the right to have your name deleted from this list. To do so, you should send a written request to the Personal Information Protection Agent at DSF.

Residents of British Columbia:

DSF may not use or communicate information on your file for marketing purposes without having obtained your prior written agreement.

Return this application to
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