

OTHER INSURANCE COVERAGES

IF YOU HAVE NO OTHER INSURANCE, CHECK THIS BOX

Last name	First name	Identification number
-----------	------------	-----------------------

Company	Type of insurance		Type of coverage (life, disability, hospital and medical expenses)	Replaced by FMRQ		Maximum amount of coverage
	individual	group		Yes ⁽¹⁾	No	

⁽¹⁾ ATTENTION - If a financial security advisor enrolls the participant, he must complete a replacement notice or prior notice, as the case may be.

ANNUAL PREMIUM

Total yearly premium for selected coverages	9% Tax	Total yearly premium including tax	Downpayment required
\$ <input type="text"/>	+ \$ <input type="text"/>	= \$ <input type="text"/>	X 1/12 = \$ <input type="text"/>

PAYMENT METHOD

Payment method - Please select one option only

OPTION #1: CREDIT CARD AUTHORIZATION MM YY
 Credit card: Visa MasterCard Card number: _____ Expiry date: ____/____
 Monthly payment Annually payment

OR

OPTION #2: PAYMENT BY CHEQUE
 MONTHLY - Payments will be made by Pre-Authorized Debit (PAD). Please enclose a sample cheque marked «VOID».
 ANNUALLY - Please enclose a cheque payable to Sogemec Assurances Inc.

TYPE OF SERVICES: PERSONAL BUSINESS

Payment information - Please complete this section if you selected the Pre-Authorized Debit (PAD) monthly payment option.

Name of account holder	Name of the financial institution	Bank account number
Full address of the financial institution		Transit number

Type of account: Personal chequing Chequing/Savings Savings Current Direct deposit account Other

Joint accounts: Is this a joint account requiring only one signature? Yes No

If more than one signature is required on withdrawals issued against the account, both account holders must sign this authorization.

Non-chequing accounts: Since approval from my/our financial institution is required for pre-authorized payments from accounts with no chequing privileges, I/we have made prior arrangements to allow for pre-authorized payments from my/our account. Enclosed is a withdrawal slip that has been stamped by my/our financial institution allowing withdrawals to be made from my/our non-chequing account.

Payment authorization

Credit card payment option

I/We hereby authorize Sogemec Assurances Inc. to make a withdrawal from my/our account on or about the first business day of each month in which insurance premiums are due. This authorization may be terminated by either Sogemec Assurances Inc. or by me through written notice. Sogemec Assurances Inc. will terminate coverage or change the method of payment to another qualifying method should a withdrawal be refused for any reason and the financial institution shall in no way be held liable should such an event occur.

Name of cardholder

Signature of cardholder

Second signature of cardholder if joint account

Date

PAYMENT METHOD (cont'd)

Pre-Authorized Debit (PAD) option

I/We authorize Sogemec Assurances Inc. to withdraw the premium amount of \$_____ from my/our bank account for monthly insurance premiums due on or after the date I/we sign this authorization. I/We authorize Sogemec Assurances Inc. to withdraw premiums on or about the first business day of each month or the next business day thereafter. Withdrawals from my/our account may be for variable amounts and may change in accordance with the insurance contract and as required to administer the policy. **I/We waive the right to receive 10 days' notice of the amount and date of each automatic withdrawal from my/our account.** If my/our bank or financial institution does not honour an automatic monthly withdrawal the first time it is presented for payment, Sogemec Assurances Inc. may attempt to withdraw that payment again within 30 days. Sogemec Assurances Inc. reserves the right to ask me/us for an alternate method of payment if my/our payment is not honoured. All one-time or automatic withdrawals from my/our bank account will be treated as personal withdrawals as defined by the Canadian Payments Association in Rule H-1. I/We and/or Sogemec Assurances Inc. can end this agreement at any time by giving 10 days' written notice. I/We understand that cancelling this PAD agreement may result in a loss of insurance coverage unless Sogemec Assurances Inc. receives another form of payment.

You may obtain a sample cancellation form by contacting your financial institution or through www.cdnpay.ca. If you have any questions about withdrawals from your bank account, contact us at 1-800-361-5303, information@sogemec.qc.ca or write to us at Sogemec Assurances Inc., C.P. 217, Succ. Desjardins, Montréal, Québec, H5B 1G9.

You have certain recourse rights if any debit does not comply with this agreement. For example, you have the right to receive reimbursement for any PAD withdrawal that is not authorized or is inconsistent with this PAD agreement. To obtain a form for a reimbursement claim, or for more information on your recourse rights, you may contact your financial institution or visit www.cdnpay.ca.

Name of account holder

Signature of account holder

Second signature of account holder

Date

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.

DECLARATION AND AUTHORIZATION FOR THE COLLECTION AND COMMUNICATION OF PERSONAL INFORMATION

Have you smoked cigarettes during the last 12 months? PARTICIPANT: Yes No SPOUSE: Yes No

I certify that the above answer is true and I agree to it being used as the basis for the requested insurance coverage. I am fully aware that any inaccurate statement may result in the cancellation of the insurance if non smoker rates were granted.

I certify that all the information contained on this application form is complete and true. I acknowledge that all the coverages offered are subject to the limitation and/or reduction clauses, as well as to the exclusions stipulated in the contract. The insurance shall become effective on the date indicated in the binding receipt. I acknowledge that I have read the information on this form and that I have kept a copy thereof. 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 the claim. A photocopy of this authorization is as valid as the original.

Signature of participant

Signature of spouse

Date

ATTENTION: Signatures are only required below if a financial security advisor has enrolled the participant.

Name (BLOCK LETTERS) and signature of financial security advisor

Check if trainee

Date

Name (BLOCK LETTERS) and signature of training supervisor

BINDING RECEIPT

EFFECTIVE DATE OF THE INSURANCE

The insurance of a resident or a graduating student becomes effective, if he/she is working and able to perform the main tasks of his/her professional occupation, or if he/she was working and able to perform the above tasks on the last day he/she was normally supposed to be, or if he/she is not working, is able to perform the main tasks of his/her usual professional occupation, at the latest of the following dates:

- a) the date on which he/she becomes eligible;
- b) the date on which he/she fills out the insurance application;
- c) the date on which the evidence of insurability is accepted by the insurer, where applicable.

If the resident or the graduating student is not actively working or is unable to perform the main tasks of his/her usual professional occupation as the result of an illness or accident on the day his/her insurance is to become effective, he/she becomes insured the day on which he/she returns to work and performs the main tasks of his/her usual professional occupation, or if he/she is not working, is able to perform the main tasks of his/her usual professional occupation.

The insurance of a medical student becomes effective if he/she is attending school and is performing his/her duties as a medical student or was performing these duties on the last day he/she normally should have been or, if he/she is not attending school, is able to perform his/her duties as a student on the latest of the following dates:

For the Life insurance coverage

- a) the date on which he/she becomes eligible;
- b) the date on which he/she fills out the insurance application;
- c) the date on which the evidence of insurability is accepted by the insurer, where applicable.

For the Loss income insurance

- a) the date on which the first-year medical student becomes eligible if his/her enrolment application and the evidence of insurability deemed satisfactory by the insurer are received by the plan administrator between October 1 and 31; the student qualifies for the automatic increases provided for in the contract without having to provide evidence of insurability;
- b) the date on which the plan administrator receives the first-year medical student's enrolment application and the evidence of insurability deemed satisfactory by the insurer if the plan administrator receives these documents between November 1 and December 31; the student qualifies for the automatic increases provided for in the contract without having to provide evidence of insurability;
- c) the date on which the evidence of insurability is accepted, in all other cases.

If a medical student is not attending school or if he/she cannot perform his/her duties as a medical student as a result of an illness or an accident on the day his/her coverage is to take effect, he/she becomes insured the day on which he/she returns to school and fully performs his/her duties as a medical student or, if he/she is not attending school, he/she is able to fully perform his/her duties as a student. However, if the student becomes disabled during the course of his/her medical studies, these automatic increases to the Income Protection Insurance cease, even after the student returns to his/her studies.

The insurance for the participant's dependent, if not hospitalized, becomes effective on the latest of the following dates:

- a) the date of the beginning of the participant's insurance;
- b) the date on which the person becomes eligible for the insurance;
- c) the date on which the evidence of insurability is accepted by the insurer, where applicable.

The insurance may not become effective before at least the first monthly premium reaches the insurer and as long as the proposed risk is insurable at the regular rate at the date on which the evidence of insurability form is completed. In the case of a substandard risk, the insurance cannot become effective before the insurer receives the evidence of insurability and the first monthly premium, including any extra premium. If the evidence of insurability required by the insurer has not been provided within the sixty (60) days following the date on which the participant signs the insurance application, the latter becomes null and void.

If a participant dies subsequent to an accident which occurred within the sixty (60) days which immediately follow the date on which he/she completed the insurance application and provided the evidence of insurability was not refused prior to the date of death, the insurance is deemed to have been effective at the time of the death.

SUICIDE

If the proposed insured commits suicide during the first two (2) years following the date of his insurance enrolment under this application, the insurer's liability is limited to the sole reimbursement of the premium paid, unless the suicide occurred while the proposed insured was suffering from a mental illness diagnosed prior to the suicide by a physician other than the participant.

CONTESTABILITY

Any declaration made by the proposed insured supporting the insurance application shall be contestable.

INTERPRETATION

Any insurance granted under this binding receipt shall be subject to the provisions of the group policy issued on behalf of the Fédération des Médecins Résidents du Québec.

EVIDENCE OF INSURABILITY

The plan shall be subject to evidence of insurability deemed satisfactory by the insurer. First-year medical students who have provided evidence of insurability deemed satisfactory by the insurer are not required to provide evidence of insurability for automatic increases for as long as they remain healthy (are not disabled).

With respect to any amount of insurance obtained without evidence of insurability, no benefit will be paid in the event of death or disability that occurs during the first 24 months after taking out coverage and that results from a pre-existing medical condition during the 36 months immediately preceding the effective date of coverage. "Pre-existing medical condition" means an injury, an illness or a physical condition, whether or not the diagnosis has been determined, for which the symptoms first manifested themselves, for which treatment was recommended, required or obtained or for which medication was prescribed or taken during the 36 months immediately preceding the effective date of coverage.

TRANSFER

You may transfer your coverages within the one hundred and eighty (180) days following receipt of your title as family physician or specialist in the FMSQ program insurance.

TERMINATION OF THE INSURANCE

This plan terminates at the latest six (6) months after the insured receives the title of family physician or specialist, without exceeding two (2) years following the termination of residency.