



**EVIDENCE OF INSURABILITY**

*Always attach copy of enrollment form or insurance application when submitting this form*

CONTRACT OR GROUP POLICY NO.

ACCOUNT OR DIVISION NO.

GROUP INSURANCE

First name, last name and address of participant		Name and address of employer	
_____ _____ _____		_____ _____ _____	
Postal Code		Postal Code	
Place of birth (province, state, country)	Certificate number	Occupation	Telephone numbers Home: Area code + No. Work: Area code + No.
Are you presently working? <input type="checkbox"/> Yes <input type="checkbox"/> No	If so, number of hours worked each week – if you are not working, state reason		

	FIRST NAME	LAST NAME	SEX	DATE OF BIRTH	HEIGHT	WEIGHT	Weight one year ago	REASON FOR CHANGE IN WEIGHT (IF APPLICABLE)
PARTICIPANT			<input type="checkbox"/> F <input type="checkbox"/> M	DD/MM/YYYY				
SPOUSE			<input type="checkbox"/> F <input type="checkbox"/> M	DD/MM/YYYY				
CHILDREN			<input type="checkbox"/> F <input type="checkbox"/> M	DD/MM/YYYY				
			<input type="checkbox"/> F <input type="checkbox"/> M	DD/MM/YYYY				

**HAVE ANY OR ARE ANY OF THE PROPOSED INSURED:**

	PARTICIPANT		SPOUSE	
	YES	NO	YES	NO
1. Ever had an application for insurance declined or modified, or approved with an exclusion or an extra premium?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Used tobacco in any form during the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Being treated by a physician or another health care professional, or taking medication?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Intending to consult a physician or another health care professional, or to undergo surgery?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Ever suffered from an infirmity, a deformity or any other physical, nervous or mental disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Ever undergone an electrocardiogram, an X-ray, a mammography, a blood test or any other examination?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Ever undergone or been advised to undergo laboratory tests for the detection of the AIDS virus or antibodies to the virus?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Ever been prescribed a diet, medication, treatment or surgery?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Ever been treated in a hospital, clinic or rehabilitation centre?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Ever claimed or received benefits or ever been absent from work for more than 10 consecutive days because of illness or an accident?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Ever been treated for alcohol or substance abuse?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Ever received diagnostic test results that were abnormal?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Ever experienced symptoms for which a health professional has not been consulted?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Ever consulted a physician or another health care professional for any physical or mental disorder not mentioned above?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Children to be insured suffered or are currently suffering from heart, lung, neurological or mental problems, cancer or diabetes, or for whom an application for insurance has been declined, rated, modified or deferred?	<input type="checkbox"/>	YES <input type="checkbox"/>	<input type="checkbox"/>	NO <input type="checkbox"/>

**IF YOU ANSWERED "YES" TO ANY OF THE ABOVE QUESTIONS, PROVIDE DETAILS.**

Question No.	First name	Nature of illnesses, operations, accidents, consultations, examinations, treatments, medication, results	Date	Duration		Name and address of physicians or hospitals
				Illness	Hosp.	
			DD/MM/YYYY			
			DD/MM/YYYY			
			DD/MM/YYYY			
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			DD/MM/YYYY			
			DD/MM/YYYY			
			DD/MM/YYYY			
			DD/MM/YYYY			

Use separate sheet if necessary.

THE PARTICIPANT MUST RETURN THE ORIGINAL TO DESJARDINS FINANCIAL SECURITY LIFE ASSURANCE COMPANY ALONG WITH HIS APPLICATION AND KEEP A COPY FOR HIS RECORDS

16. What is your weekly consumption or use of:	PARTICIPANT	tobacco	alcoholic beverages	narcotics or drugs	SPOUSE	tobacco	alcoholic beverages	narcotics or drugs	
17. Is there any history in your family (father, mother, brothers, sisters) of heart disease, stroke, high cholesterol, high blood pressure, diabetes, kidney disease, multiple sclerosis, Huntington's chorea, polyposis coli, cancer, Alzheimer's disease, Parkinson's disease, muscular dystrophy, motor neuron disease or other hereditary diseases? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please complete the table below. For cancer, indicate the location.									
Check the Family Member				Illnesses (if cancer, specify type)			Age at onset of the illness	Age if alive	Age at death
PARTICIPANT	Father	Mother	Brother	Sister					
	Father	Mother	Brother	Sister					
SPOUSE	Father	Mother	Brother	Sister					
	Father	Mother	Brother	Sister					

### PERSONAL INFORMATION MANAGEMENT

Desjardins Financial Security Life Assurance Company (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 the Company's various financial services (insurance, annuities, credit, etc.). 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 Life Assurance Company  
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.

### NOTICE REGARDING THE MIB

Information regarding your insurability will be treated as confidential. Desjardins Financial Security Life Assurance Company or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a non-profit membership organization of insurance companies, which operates an information exchange on behalf of its member. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 416-597-0590. If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth on its website at www.mib.com. The address of MIB's information office is 330 University Avenue Suite 501, Toronto, Ontario M5G 1R7.

Desjardins Financial Security Life Assurance Company, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

### DECLARATION AND AUTHORIZATION FOR THE COLLECTION AND COMMUNICATION OF PERSONAL INFORMATION

I authorize Desjardins Financial Security Life Assurance Company, strictly for the purposes of determining my insurability, managing my file and settling my claims to: (a) collect from any person or legal entity, or from any public or parapublic organization, only the information deemed necessary to manage my file. The non-exhaustive list of sources from which information may be collected includes health care professionals or facilities, the MIB (formerly known as Medical Information Bureau), insurance companies, personal information officers or investigation agencies, the policyholder, my employer or former employers; (b) communicate to the said persons or organizations only the personal information about me that is deemed necessary for the purposes of my file; (c) when necessary, request an inquiry report about me, and also use the personal information it may have about me in existing files that are now closed. This consent is also for the collection, use and communication of personal information concerning my minor children, insofar as applicable to the claim. A photocopy of this authorization is as valid as the original. I hereby certify that the answers given above are complete and true and I agree that they form an integral part of my application for insurance. I hereby acknowledge that I have read the notice regarding personal information management, as well as the notice regarding the MIB and that I have received a copy thereof. The insurance will become effective on the date indicated on the contract. Any false declaration may result in the cancellation of the insurance. If the Desjardins Financial Security Life Assurance Company medical director deems appropriate, I authorize him to send the information that he obtained to analyze my application or that supports the Company's decision to the following physician:

Name and address of physician			
			DD/MM/YYYY
Signature of participant	Signature of spouse	Signature of witness	Date
Signature of dependent children aged 16 and over to be insured (aged 14 and over for Québec)			

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