

A - REQUEST FOR EXEMPTION

B - APPLICATION FOR ENROLMENT FOLLOWING THE TERMINATION OF EXEMPTION

IDENTIFICATION – This section must always be completed

Name of employer	Group or contract number	Division or account number
Last name of member or participant	First name	Identification or certificate number

A - REQUEST FOR EXEMPTION

IDENTIFICATION OF SIMILAR PLAN			
<input type="checkbox"/> My spouse's plan: last and first names _____ <input type="checkbox"/> Other plan			
Name of employer			
Name of insurer	Contract number	Identification number	Effective date of similar plan coverage YY MM DD
<p>I declare that:</p> <p>The group insurance coverages subscribed by my employer with Desjardins Financial Security were offered to me and explained in detail. Since I am already covered by similar coverages under the above-mentioned group insurance plan, I choose to renounce the following coverage(s):</p> <p style="text-align: center;">MEMBER OR PARTICIPANT AND DEPENDENT(S)</p> <p style="text-align: center;"> <input type="checkbox"/> Plan which includes drugs insurance <input type="checkbox"/> Complementary health plan <input type="checkbox"/> Dental care plan </p> <p>I understand that in order to become eligible for insurance again, I must prove to the satisfaction of the insurer that it has become impossible to remain insured under this plan. I also understand that I may have to establish my insurability or that of my dependents according to contract provisions and at my expense if I apply more than 31 days after the end of the similar plan.</p> <p>I am enclosing a copy of the insurance certificate for the similar plan with this request for exemption. I certify that the above information is complete and true.</p>			
_____ Signature of member or participant	_____ Signature of employer's representative	_____ Date	

B - APPLICATION FOR ENROLMENT FOLLOWING THE TERMINATION OF EXEMPTION

Date from which it has become impossible for me to remain insured under the plan which justified my exemption:	YY MM DD _____	
Reason for the termination of the insurance plan: _____		
I am applying for insurance again since I am no longer covered under a group insurance plan offering comparable benefits.		
With this application for enrolment, I am enclosing evidence that it has become impossible for me to remain insured under the similar plan. I certify that the above information is complete and true.		
_____ Signature of member or participant	_____ Signature of employer's representative	_____ Date