Desjardins Financial Security™

200, rue des Commandeurs
Lévis (Québec) G6V 6R2

EVIDENCE OF INSURABILITY REPORT

THIS REPORT MUST BE COMPLETED BY THE PROPOSED INSURED, WHO MUST READ THE INSTRUCTIONS BELOW VERY CAREFULLY

Confirmation number	Identification number of participant
Name of participant	

INSTRUCTIONS

1- If you have not provided the insurer with an evidence of insurability report during the last six months, please complete Sections A, B and D.

2- If an evidence of insurability report has been provided within the last 6 months (date of signature), complete Sections A, C and D, and follow the instructions indicated in Section B.

3- Give a complete and accurate answer to each question and sign your name in the two places provided for this purpose in Section D. If the proposed insured is a child aged 14 or over, Section D, "DECLARATION AND AUTHORIZATION", must be signed by the father, mother or guardian and child. It is your responsibility to forward this document. Do not hesitate to contact the staff of your financial institution to check whether your forms have been sent to the insurer.

A - IDENTIFICATION OF THE INSTITUTION AND THE PROPOSED INSURED

Name of the financial institution		Name of the agent	
Identification number	Telephone number ( ) -	Extension	Folio number
Name of proposed insured		Given name(s)	
Name at birth if different from above		Sex ☐ M ☐ F	Date of birth Y / M / D
Place of birth: (province, state, country)	Telephone (home) ( ) -		Telephone (work) ( ) -
Current address			Postal Code
Future address, if applicable			Postal Code
Date you will be moving to this new address Y / M / D			
Profession or occupation	Are you working presently? ☐ yes ☐ no - If so, number of hours per week - If not state the reasons?		

B - EVIDENCE OF INSURABILITY

PLEASE ANSWER EACH OF THE FOLLOWING QUESTIONS. GIVE DETAILS FOR EACH ANSWER. IF NEEDED, USE A SEPARATE DATED AND SIGNED SHEET.

Height	Current weight	Weight one year ago	Reason for weight change if 4,5 kg (10 lbs) or more
☐ ft ☐ m	☐ lbs ☐ kg	☐ lbs ☐ kg	

Family history	Age if alive	Age at death	State of health or cause of death	Family history	Age if alive	Age at death	State of health or cause of death
Father				Brothers			
Mother				Sisters			

1 (a) Do you consume any the following: Alcoholic beverages? ☐ Yes ☐ No Narcotics? ☐ Yes ☐ No Other drugs? ☐ Yes ☐ No

(b) Weekly quantity

(c) Have you ever made a greater use of the above? ☐ Yes ☐ No
If so, state habit involved. Since when and why have you changed habits?

(d) Have you ever had your driver's license revoked or suspended during the past 5 years? ☐ Yes ☐ No If so, indicate the dates and the reason

2 (a) Do you consume tobacco (cigarettes, cigarillos, cigars, the pipe, marijuana, patches, nicotine gum or any medication to help stop smoking) ☐ Yes ☐ No

(b) Weekly quantity

(c) Have you used or smoked tobacco in any form (cigarettes, cigarillos, cigars, the pipe, marijuana, patches, nicotine gum or any medication to help stop smoking during the last twelve months? ☐ Yes ☐ No

3 (a) Are you under the care of a physician or a health professional?	YES	NO	If so, specify reasons, dates of consultations, name and address of physician(s) or health professional(s).
(b) Do you intend to consult a physician or a health professional in the near future?	YES	NO	
(c) Have you consulted a physician or health professional in the last 2 years?	YES	NO	
4 Did he/she recommend any medication?	YES	NO	If so, name of medication, reason, daily dosage, duration, date
treatment?	YES	NO	If so, state type of treatment, frequency, duration, date
5 Do you take any medication?	YES	NO	If so, name of medication, reason, daily dosage, since when?
6 Do you suffer from a handicap, deformity, or other physical, nervous or mental disorder or illness?	YES	NO	If so, nature of disorder and since when?
7 Have you ever been examined by a physician for the acquired immunodeficiency syndrome (AIDS), an AIDS related illness or any other immunological disorder or have you had any related symptoms?	YES	NO	If so, state results, name and address of physician or health facility, and date
8 (a) Have you ever undergone surgery or been advised to undergo surgery?	YES	NO	If so, state type of and reason for surgery or tests, results (if necessary), name and address of physician or health facility, and date
(b) Have you ever undergone an electrocardiogram, laboratory tests or other tests?	YES	NO	
(c) Have you ever been treated in a health care facility?	YES	NO	
9 Have you ever been unable to work further to a disability?	YES	NO	If so, state reasons, dates, length of absences from work
10 Have you ever had an application for insurance ☐ declined, ☐ modified, ☐ accepted with an extra premium or ☐ cancelled by an insurer, including Desjardins Financial Security Life Assurance Company?	YES	NO	If so, state date, reason, name and address of the company

C - EVIDENCE OF INSURABILITY SUMMARY

(TO BE USED ONLY IF AN EVIDENCE OF INSURABILITY REPORT HAS BEEN PROVIDED WITHIN THE LAST 6 MONTHS)

1- Have you used or smoked tobacco in any form during the last twelve months? ☐ Yes ☐ No

2- In addition to the tests required to study your insurance application, which was signed on YEAR MONTH DAY (signature dating less than 6 months) and accepted, have you consulted or been treated by a physician, undergone any other types of tests or had an accident since this date? ☐ Yes ☐ No

- If the answer to question 2 is "YES", complete Section C and D.
- If the answer to question 2 is "NO", sign your name in the two places in Section D.

D - DECLARATION AND AUTHORIZATION WITH RESPECT TO 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:

- collect from any natural person or legal entity, or from any public or parapublic organization, only the information deemed necessary to manage my file. The non-exaustive list of sources from which information may be collected includes health care professionals or facilities, the Medical Information Bureau, insurance companies, personal information officers or investigation agencies, the policyholder, my employer of former employers;
- communicate to the said persons or organizations only the personal information about me that is deemed necessary for the purposes of my file;
- 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 applies also to the collection, use and communication of personal information regarding my minor children who are to be insured under this insurance application. A photocopy of this authorization is as valid as the original.

I hereby certify that the answers given above are complete and true. I agree that they form an integral part of my application for insurance. I have read the notice on the back of this form and received a copy thereof. The insurance will become effective in accordance with instructions given in the Applicant's guide, the provisions forming an integral part of the application for insurance and the provisions of the policy, subject to the approval, by the insurer, of the evidence of insurability required for the assesment of my file. In the event of the refusal of my application, the insurer undertakes to inform me of such refusal.

If the medical director of Desjardins Financial Security Life Assurance Company deems it necessary, I authorize him to communicate to my physician the results of the tests obtained for the assesment of this application or the reasons which support the decision of the Company. Name and address of physician.

Signature of proposed insured (father, mother or legal guardian and child aged 14 or over)	Signature of witness	Date Y / M / D

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COMPULSORY - IF THE AUTHORIZATION BELOW IS NOT SIGNED AND DATED, WE WILL BE UNABLE TO PROCEED WITH THE REVIEW OF YOUR INSURABILITY.

AUTHORIZATION WITH RESPECT TO 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:

- collect from any natural person or legal entity, or from any public or parapublic organization, only the information deemed necessary to manage my file. The non-exaustive list of sources from which information may be collected includes health care professionals or facilities, the Medical Information Bureau, insurance companies, personal information officers or investigation agencies, the policyholder, my employer of former employers;
- communicate to the said persons or organizations only the personal information about me that is deemed necessary for the purposes of my file;
- 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 applies also to the collection, use and communication of personal information regarding my minor children who are to be insured under this insurance application. A photocopy of this authorization is as valid as the original.

Signature of proposed insured (father, mother or legal guardian and child aged 14 or over)	Signature of witness	Date Y / M / D

THE INSURER RESERVES THE RIGHT TO REQUEST ADDITIONAL INFORMATION OR MEDICAL EXAMINATIONS DEEMED NECESSARY FOR THE ASSESSMENT OF YOUR FILE. **ANY FALSE STATEMENT WILL RESULT IN THE CANCELLATION OF THE INSURANCE.**

- RETURN THE ORIGINAL TO DESJARDINS FINANCIAL SECURITY
CONTRACT ADMINISTRATION, GROUP INSURANCE PLAN FOR EMPLOYEES AND RETIREES OF THE DESJARDINS GROUP
200, AVENUE DES COMMANDEURS, LÉVIS (QUÉBEC) G6V 6R2

- KEEP A COPY

NOTICE REGARDING THE MEDICAL INFORMATION BUREAU

The information concerning your insurability is treated confidentially. However, Desjardins Financial Security Life Assurance Company or its reinsurers may provide a summary to the Medical Information Bureau, a non-profit organization created by life insurance companies in order to exchange information. If you enroll in life or health insurance with a company that is a member of the Bureau or if you file a claim for benefits or indemnities, the Bureau will provide the company with the information it holds regarding you upon request.

Desjardins Financial Security Life Assurance Company or its reinsurers may also communicate information contained in their records to another life insurance company to which you have submitted a life insurance or health insurance application, or a claim.

The Bureau will inform you of the information in your file upon receipt of such a request. If you question the exactitude of the Bureau's information, you may ask that the information be rectified by writing to the Medical Information Bureau, 330 University Avenue, Toronto, Ontario, M5G 1R7 - Telephone: 1-866-692-6901 (TTY 1-866-346-3642).

NOTICE REGARDING THE INVESTIGATIVE REPORT

We hereby inform you that, as part of the normal review of your application, an investigative report may be requested in order to collect information from personal interviews with your acquaintances. The investigation may concern your reputation, your lifestyle and your finances. A representative from a company hired to compile such a report may visit or call you.