Desjardins
Insurance
LIFE • HEALTH • RETIREMENT

1, Complexe Desjardins
Montréal (Québec) H5B 1E2

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

95 St. Clair Avenue West
Toronto ON M4V 1N7

Contract: ____________

Request for change without evidence

Important information

1. When applying for a conversion, Guaranteed Insurability Benefit/Periodic Purchase Option or a change to a universal life contract, an illustration is required.
2. For conversions and the Guaranteed Insurability Benefit/Periodic Purchase Option, the new coverage will be issued under a new contract.
3. If evidence of insurability is required, please complete the Insurance Application Life, Health and Disability (07002E).
4. To change policyowner, please complete the Request for title changes (09614A).
5. If your contract has been assigned or if it has an irrevocable beneficiary, please obtain their signature in **section I.**
6. If your client is presently disabled (totally or partially), they cannot exercise the future insurability option or the exchange privilege.

Representative information

Compensation: ☐ Career ☐ Accelerated ☐ Not applicable

First and last names of representative(s) (BLOCK LETTERS)	**Representative code**	Field office code	% share	Email address

100%

Desjardins Insurance refers to Desjardins Financial Security Life Assurance Company.

Use of the masculine should be understood to include both men and women.

A - General information

Policyowner 1		**Policyowner 2** ☐ Same address as **Policyowner 1**	
Name		Name	
Address		Address	
City	Province	City	Province
Postal code	Date of birth (YYYY/MM/DD)	Postal code	Date of birth (YYYY/MM/DD)
Email		Email	
Telephone Home: ______ Work: ______,	Cell: ______ ext.: ______	Telephone Home: ______ Work: ______,	Cell: ______ ext.: ______

Declaration of tax residence

- When applying for a change to a life insurance coverage with cash surrender values or a savings component, the Declaration of tax residence must be completed. For more information, please refer to the documents on *web*.
- If the policyowner is a corporation, trust or other entity, please fill out form **08295E** for the declaration of tax residence.

Policyowner 1

Check all of the options that apply to you.

☐ **I am a tax resident of Canada.**
If you check this box, give your social insurance number:

______

☐ **I am a tax resident or a citizen of the United States.**
If you check this box, give your U.S. Taxpayer Identification Number (TIN):

______

If you do not have a TIN, have you applied for one?
☐ Yes ☐ No

☐ **I am a tax resident in a country other than Canada or the United States.**

If you check this box, give your countries of tax residence and taxpayer identification numbers.

If you do not have a TIN, give the reason using one of the following choices:

Reason A: I will apply or have applied for a TIN but have not yet received it.

Reason B: My country of tax residence does not issue TINs to its residents.

Reason C: Other reason.

Country of tax residence	TIN	If you don't have a TIN, choose reason A, B, or C. If "C", please specify.

☐ I will provide any missing information on my declaration of tax residence to Desjardins Financial Security Life Assurance Company **within 90 days.**

Policyowner 2

Check all of the options that apply to you.

☐ **I am a tax resident of Canada.**
If you check this box, give your social insurance number:

______

☐ **I am a tax resident or a citizen of the United States.**
If you check this box, give your U.S. Taxpayer Identification Number (TIN):

______

If you do not have a TIN, have you applied for one?
☐ Yes ☐ No

☐ **I am a tax resident in a country other than Canada or the United States.**

If you check this box, give your countries of tax residence and taxpayer identification numbers.

If you do not have a TIN, give the reason using one of the following choices:

Reason A: I will apply or have applied for a TIN but have not yet received it.

Reason B: My country of tax residence does not issue TINs to its residents.

Reason C: Other reason.

Country of tax residence	TIN	If you don't have a TIN, choose reason A, B, or C. If "C", please specify.

☐ I will provide any missing information on my declaration of tax residence to Desjardins Financial Security Life Assurance Company **within 90 days.**

Name(s) of the proposed insured	Name(s) of the proposed insured

B - Changes requested

Please complete a new insurance application if, on a change/conversion request, the amount of insurance requested is increased, a change to preferred rates is applied for or an additional coverage is requested (other than the Accidental Fracture or the Accidental Dismemberment or the Loss of Use coverages).

Please check appropriate box

☐ Add child to Children's Life Protection coverage in force		☐ Decrease amount of insurance to: $
First name	Last name at birth	☐ Exercise Reduced Paid-up Option
Sex ☐ F ☐ M	Date of birth (YYYY/MM/DD)	☐ Insurability option
☐ Add Accidental Fracture coverage or Accidental Dismemberment or Loss of Use coverage		☐ Levelling of costs of insurance (universal life contract)
☐ Cancel coverages or remove insureds		☐ Split of the policy [2]
☐ Cancel Indexation		☐ Triennal increase (Independent Living - COLA Benefit)
☐ Change Enriched Death Benefit to Level Death Benefit		☐ Other:

☐ Group conversion [1, 3] ________ Amount ________ New coverage

☐ Full conversion [1, 4] ________ New coverage

☐ Children/Family Protection Conversion [1, 4] ________ Amount ________ New coverage

☐ Partial conversion [1, 4] ________ Amount ________ New coverage
☐ Termination of existing coverage
☐ Decrease amount of insurance of existing coverage

☐ Guaranteed Insurability Benefit/Periodic Purchase Option exercised as a result of the following [1, 4]:

☐ Age ________ ☐ Married on ________ Date (YYYY/MM/DD) ☐ Child ________ Name born on ________ Date (YYYY/MM/DD)

☐ Business Insurability Option[4]

Be sure to provide the following information[1]:

- Business financial statements for the last 3 years
- Confirm the insured's share in the company
- Confirm that the company is still the policyowner and that it did not change since the issue

Evoluvie - For Quebec Only ☐ Coverage period ☐ Maturity values ☐ Premium period

Change in dividend option (Participating Whole Life coverage only)

☐ **From** Enhanced insurance **to** Paid-up additions

☐ **From** Paid-up additions **to** ☐ Dividends on deposit
☐ Annual premium reduction
☐ Cash payment

From : ☐ Dividends on deposit
☐ Annual premium reduction
☐ Cash payment

To: ☐ Dividends on deposit
☐ Annual premium reduction
☐ Cash payment

(1) An illustration is required for these changes.

(2) A $50 change fee must be submitted with a request for a universal life contract split. Inquire about other requirements necessary to process the split before submitting this request.

(3) For a Group Conversion, please return with this form the completed Request for Conversion (01071E for provinces other than Quebec; 01297E for Quebec).

(4) The new coverage will be issued under a new contract.

SOLO DISABILITY

C - Changes requested for SOLO Disability coverages

Please check appropriate box

☐ Increase the waiting period : ________________ days	☐ Remove a rider (specify which rider): ________________
☐ Reduce the monthly benefit: $ ________________	☐ Changing in the premium structure from T10 to T65
☐ Reduce the benefit period: ________________ years	☐ Other:

For the **above** changes, you do not have to complete any other questions.

☐ Exercice of the Future Insurability Option
- Please complete **section D** (questions 1 to 15) and **section E,** and provide the financial evidence below if applicable.
- To be applied for at least 30 days before the coverage anniversary.

Financial evidence to be provided - SOLO Disability Income			**SOLO Loan Insurance**
Salaried employees		**Self-employed workers or business owners**	
Without Guaranteed benefit	With Guaranteed benefit	If all of the insured's disability benefits (including this change request and any disability benefits in force with Desjardins Insurance or other companies identified in **section E**) total $3,000 or more: • Tax returns from the last 2 years • Financial statement (from last full year)	No financial proof
No financial proof	• 3A/4A : Tax returns from the last 2 years • A/2A : Tax returns from the last 3 years		

Exchange clause

☐ SOLO Disability Income to SOLO Business Expense	Please complete **section D** (questions 1 to 16) and **section E.**
☐ SOLO Business Expense to SOLO Disability Income	Please complete **section D** (questions 1 to 15) and **section E.**
☐ SOLO Loan Insurance to SOLO Disability Income	Please complete **section D** (questions 1 to 15) and **section E.**
☐ SOLO Disability Income to SOLO Loan Insurance	Please complete **section D** (questions 1 to 9) and **section E.**

D - Eligibility for modifications of SOLO Disability coverages

Specific situation

1. Are you disabled (totally or partially)? ☐ Yes ☐ No
   Note: If you answered "**Yes**" to this question, you are not eligible to exercise the future insurability option or the exchange privilege.
2. If you are a female, are you pregnant? ☐ Yes ☐ No
3. Are you on precautionay cessation of work or on parental leave? ☐ Yes ☐ No

Employement profile

4. Profession or occupation:
5. Professional designation/diploma obtained (level of education):
6. Date you began working in your current occupation (YYYY/MM/DD) ________________
   If less than 3 years, indicate previous occupation: ________________
7. **Responsibilities and duties** – Indicate the percentage of your time spent on each type of responsibility and **list the specific activities involved** in the "Duties" column.

Responsibilities	**Percentage**	**Duties**
a) Manual/Physical		
b) Management/Office work		
c) Sales		
d) Supervision		
e) Other, specify:		
Total	100%	
f) Indicate the percentage of travel outside of North America:	%	

8. Number of hours worked per week: ________________
9. Number of weeks worked per year: ________________ weeks/year

D - Eligibility for modifications of SOLO Disability coverages (cont.)

Insurable net annual earned income profile (earned income after overhead expenses but before taxes)

10. Earned income based on your current employment situation

a) ☐ Employee (Amount reported on T1 Federal Tax Return; line 101 plus line 104, minus line 229.)	Annual income	Annual income (last year)	Annual income (prior to last year)
	$	$	$
b) ☐ Worker paid on commission c) ☐ Self-employed worker d) ☐ Partners (Net income reported on your T1; lines 135 to 143. The income to date is the income for the current fiscal year.)	Income to date (current year)	Total income (last year)	Total income (prior to last year)
	$	$	$
e) ☐ Owner of a corporation (Amount reported on your T1: lines 101 and 104 plus your share of the profits or losses.)		Last year	Prior to last year
	Salary	$	$
	Corporation's profit or (loss)	$	$
	Total	$	$
	Fiscal year-end (YYYY/MM/DD):		
f) ☐ Recognized Agricultural Producer: (Income including amortization expenses)	Annual income	Annual income (last year)	Annual income (prior to last year)
	$	$	$

11. If you are self-employed, do you split your income for tax purposes? ☐ Yes ☐ No
    If "**Yes**", what is the income splitting amount? $

12. Calculate your unearned income from last year and estimate your unearned income for this year.
    Does one of these amounts exceed the lesser of the following: $30,000 or 15% of the income you reported in question 10? ☐ Yes ☐ No
    (Unearned income is income from sources other than your profession and is income that you still receive even if you were disabled. Example: investment income, rental or copyrights, etc.)
    If "**Yes**", complete question 14 - Unearned income sources.

13. Does your net worth (assets minus liabilities) exceed $4,000,000? ☐ Yes ☐ No
    If "**Yes**", complete question 15 - Net Worth.

14. Unearned income sources (Unearned income sources are excluded from the insurable net earned income declared in **question 10**.)

Net profit from rental income	$
Capital gains	$
Non-professional dividends	$
Interest	$
Other (specify)	$
Total	$

15. Net worth

Savings, liquid assets, stocks, bonds	$
Business assets (excluding goodwill)	$
Personal property	$
Real estate property	$
Other (specify)	$

SOLO DISABILITY

SOLO DISABILITY

D - Eligibility for modifications of SOLO Disability coverages (cont.)

16. Business Expense coverage (proposed insured's share of monthly expenses). For SOLO Agriculture, do not complete items l), m) and n).

a) Rent, hydro, telephone and other public utilities	$	h) Interest expense	$
b) Employee salaries	$	i) Business taxes and licenses	$
c) Cleaning services	$	j) Postage and office supplies	$
d) Professional services of an outside accountant	$	k) Property tax on business site	$
e) Property and casualty insurance premium	$	l) Leasing and amortization of equipment, including vehicle	$
f) Professional dues	$	m) Depreciation of equipment and premises belonging to proposed insured	$
g) Professional liability insurance	$	n) Amortization or regular loan payments, including mortgages	$
o) Periodic repayment of capital under loans taken out for unamortized assets (SOLO Agriculture only)			$

Total of monthly expenses (add both columns): $

E - Insurance in force

- To be completed if the changes requested are from **section C**.
  If this section is not completed, your application can be delayed.

SOLO Disability coverages ☐ **Insured 1** or ☐ **Insured 2**

Do you have any disability insurance in force (not considering this application)? ☐ Yes ☐ No

If "**Yes**", indicate the total amount of disability coverage currently in force (including Desjardins Financial Security Life Assurance Company but excluding this application) and including coverage offered by your employer, if applicable.

Indicate your disability insurance in force	Issue date (YYYY/MM/DD)	Monthly benefit	Waiting period	Benefit period	Taxable
Name of insurer Type of coverage ☐ Individual ☐ Group ☐ Loan ☐ Overhead expenses					☐ Yes ☐ No
Name of insurer Type of coverage ☐ Individual ☐ Group ☐ Loan ☐ Overhead expenses					☐ Yes ☐ No
Name of insurer Type of coverage ☐ Individual ☐ Group ☐ Loan ☐ Overhead expenses					☐ Yes ☐ No

Are you eligible to receive benefits from:
a) Employment Insurance (EI)? ☐ Yes ☐ No
b) Workers' Compensation Plan - CNESST (formerly the CSST) / WCB / WSIB / WHSCC? ☐ Yes ☐ No

F - Changes requested for SOLO Healthcare coverages

Reduce the Health Plus coverage

☐ Basic plan

Remove a rider (check the rider you want to remove)
Please note that if you remove the Drugs rider, the "Dental Benefit" rider will be removed automatically.

☐ Drugs ☐ Dental Benefit ☐ Hospitalization

Remove an insured

☐ Spouse ☐ Child

G - Beneficiaries

G1 - Beneficiaries - Upon death

This section must be completed for a beneficiary designation of a new coverage.
The percentages allocated to an insured's beneficiaries must add up to 100%.

☐ This designation is for the entire policy. ☐ This designation is for the new coverage only.

Beneficiary(ies) for proposed insured 1	%	Date of birth (YYYY/MM/DD)	Beneficiary's relationship to: - **Policyowner,** for contracts issued in Quebec - **Proposed insured,** for contracts issued in provinces other than Quebec	Sex	Status
First name Last name			☐ Married ☐ Civil union spouse (Quebec only) ☐ Common-law spouse ☐ Other:	☐ F ☐ M	☐ Revocable ☐ Irrevocable
First name Last name			☐ Married ☐ Civil union spouse (Quebec only) ☐ Common-law spouse ☐ Other:	☐ F ☐ M	☐ Revocable ☐ Irrevocable
First name Last name			☐ Married ☐ Civil union spouse (Quebec only) ☐ Common-law spouse ☐ Other:	☐ F ☐ M	☐ Revocable ☐ Irrevocable
First name Last name			☐ Married ☐ Civil union spouse (Quebec only) ☐ Common-law spouse ☐ Other:	☐ F ☐ M	☐ Revocable ☐ Irrevocable
First name Last name			☐ Married ☐ Civil union spouse (Quebec only) ☐ Common-law spouse ☐ Other:	☐ F ☐ M	☐ Revocable ☐ Irrevocable
Beneficiary(ies) for proposed insured 2					
First name Last name			☐ Married ☐ Civil union spouse (Quebec only) ☐ Common-law spouse ☐ Other:	☐ F ☐ M	☐ Revocable ☐ Irrevocable
First name Last name			☐ Married ☐ Civil union spouse (Quebec only) ☐ Common-law spouse ☐ Other:	☐ F ☐ M	☐ Revocable ☐ Irrevocable
First name Last name			☐ Married ☐ Civil union spouse (Quebec only) ☐ Common-law spouse ☐ Other:	☐ F ☐ M	☐ Revocable ☐ Irrevocable
First name Last name			☐ Married ☐ Civil union spouse (Quebec only) ☐ Common-law spouse ☐ Other:	☐ F ☐ M	☐ Revocable ☐ Irrevocable
First name Last name			☐ Married ☐ Civil union spouse (Quebec only) ☐ Common-law spouse ☐ Other:	☐ F ☐ M	☐ Revocable ☐ Irrevocable

G2 - Contingent beneficiaries

If a beneficiary dies before the proposed insured, the contingent beneficiary replaces this beneficiary.

Beneficiary for proposed insured 1	Date of birth (YYYY/MM/DD)	Contingent beneficiary's relationship to: - **Policyowner,** for contracts issued in Quebec - **Proposed insured,** for contracts issued in provinces other than Quebec	Sex	Status
First name Last name		☐ Married ☐ Civil union spouse (Quebec only) ☐ Common-law spouse ☐ Other:	☐ F ☐ M	☐ Revocable ☐ Irrevocable
Beneficiary for proposed insured 2				
First name Last name		☐ Married ☐ Civil union spouse (Quebec only) ☐ Common-law spouse ☐ Other:	☐ F ☐ M	☐ Revocable ☐ Irrevocable

H - Payment and premium instructions

H1 - Premium mode and method

Mode	☐ Annual **$** ______	☐ Semi-annual **$** ______		☐ Monthly **$** ______
Method	☐ Automatic withdrawal (PAD) - Please **complete section H2.**			
	☐ Cheque (direct billing - not available with monthly premium)			
		Required if a new contract is to be issued		
Initial Premium	☐ On delivery (COD)	☐ Cheque included with this application		☐ Automatic withdrawal (PAD) - Please **complete section H2.**
	☐ Use of cash values from contract number(s)	No.:	No.:	No.:

H2 - Pre-authorized debit agreement (PAD) ☐ To be provided on delivery

Complete this section when "Automatic withdrawal" is selected as the method of payment. **To be valid, account holder(s) must sign the PAD portion of section I on page 9.**
Only a valid chequing account (not a line of credit account) can be used.

Account holder name and account number

Last and first names of account holder(s)		Telephone number
Address – No., street, apt.		Postal code
Name and address of financial institution	Transit number	Account number

Authorization of withdrawal

I authorize Desjardins Financial Security Life Assurance Company (hereinafter called “Desjardins Insurance”) and the financial institution where I have my account or any other financial institution I may appoint, to debit the following amount(s) according to my instructions, at the frequency indicated:

☐ Monthly ☐ Semi-annual ☐ Annual

Draw date* (select between 1st and 28th): ______ **Amount of premium: $**______

* **For a universal life contract, the draw date will be the issue date of the contract.**

Contract number(s)	Amount to be withdrawn
	Total

Special instructions (If applying for a premium deposit account, please provide the direction below.)

Type of PAD Agreement ☐ Personal ☐ Business

Waiver

I agree to waive any written notice before the first debit is made or when any change is made to the above debit.

Change or cancellation
I will advise Desjardins Insurance of any changes to this Agreement at least 10 business days prior to the next withdrawal.

I can cancel this Agreement at any time by sending a notice to Desjardins Insurance at least 10 business days prior to the next withdrawal.

I may obtain a sample cancellation form or more information on my right to cancel a PAD agreement by consulting my financial institution or by visiting www.cdnpay.ca.

The cancellation of this Agreement does not terminate the Policyowner's obligations under his contract(s).

Desjardins Insurance can cancel the PAD Agreement by sending a 30-day notice to the Policyowner. The Agreement can also be cancelled if the financial institution refuses the pre-authorized debits for any reason.

Reimbursement
I have certain rights of recourse if a PAD does not comply with the terms of this Agreement. For example, I have the right to receive a reimbursement for any PAD that is not authorized or that is not compatible with the terms of this PAD Agreement. For more information on my rights of recourse, I may consult with my financial institution or visit www.cdnpay.ca.

Authorization to collect and communicate personal information
I consent to the disclosure of the personal information in this Agreement to Desjardins Insurance's financial institution and to the holder of the contract(s) paid through this Agreement.

IMPORTANT: Attach a personal cheque marked "VOID" to avoid errors in transcription.

I - Statements and authorizations

1. The policyowner and the proposed insureds declare that all answers provided in this form are true and complete.
2. The policyowner agrees to modify their contract based on the information provided in this form.
3. Each proposed insured agrees to have insurance issued on them.
4. The policyowner acknowledges that:
   a) the information provided on their "Declaration of tax residence" is correct and complete (if applicable). They agree to give Desjardins Financial Security Life Assurance Company (hereinafter called "Desjardins Insurance") a new declaration within 30 days in the event of any change in circumstances;
   b) they will provide Desjardins Insurance any missing information on their "Declaration of tax residence" within 90 days.

X ______________________________
Signed at (city or town, province)

X ______________________________
Date (YYYY/MM/DD)

X ______________________________
Signature of policyowner 1 (and proposed insured 1 or 2 if the same person)

X ______________________________
If policyowner 1 is a corporation, trust or other entity, indicate the name and title of the person authorized to sign on its behalf

X ______________________________
Signature of policyowner 2 (and proposed insured 1 or 2 if the same person)

X ______________________________
If policyowner 2 is a corporation, trust or other entity, indicate the name and title of the person authorized to sign on its behalf

X ______________________________
Signature of proposed insured 1 (if not policyowner 1 or 2)

X ______________________________
Signature of proposed insured 2 (if not policyowner 1 or 2)

X ______________________________
Signature of guardian for children **under 18 years** (Quebec) or legal representative for children **under 16 years** (provinces other than Quebec)

Pre-authorized debit agreement (PAD)
I authorize Desjardins Financial Security Life Assurance Company to debit my account held at the financial institution indicated and according to the period and amounts indicated in **section H** of this application. Moreover, I acknowledge having read the terms and conditions regarding the PAD in **section H** of this form and I understand that, to the extent possible, I will receive a copy of the signed authorization. I will not receive any other confirmation prior to the first payment.

X ______________________________
Signature of account holder

X ______________________________
Date (YYYY/MM/DD)

X ______________________________
Signature of the second account holder
(Only if two signatures are required)

X ______________________________
Date (YYYY/MM/DD)

Consent for changes requested, if applicable
I, the undersigned, ______________________________, as the ☐ Irrevocable beneficiary of the contract to which the changes apply ☐ Creditor who holds a guarantee on the contract of the contract to be modified, states that I authorize all changes requested in this form.

X ______________________________
Signature of irrevocable beneficiary

X ______________________________
Signature of creditor who holds a guarantee on the contract

X ______________________________
Signature of irrevocable beneficiary

X ______________________________
Date (YYYY/MM/DD)

X ______________________________
Signature of the representative

X ______________________________
Signature of the supervisor (Quebec only)

____
Name (BLOCK LETTERS) of the representative

____
Name (BLOCK LETTERS) of the supervisor (Quebec only)

____
Signed at

____
Date (YYYY/MM/DD)

J - Special instructions

- Provide additionnal details relevant to the request for change.