DESJARDINS FINANCIAL SECURITY
Insurance Information

Your LTD group insurance provides:

Long Term Disability	$500/month $750/month $1000/month
Life Insurance	$10,000
AD&D	$10,000 up to

Facts

All items above are non taxable

Payments taken directly from your paycheque

No medical questionnaire to fill (pre-existing condition clause may apply with in the first year)

You are covered 24 hours a day, 7 days a week

You must belong to a category of covered union employees & work on average 18.75 hours/week.

Provincial Health Care Workers : Ambulance New Brunswick: Department of Education: Department of Transportation: NB Liquor : Nursing Home Worker

The waiting period prior to the payment of benefits under the LTD coverage is 120 days. During this time you are responsible for paying your premiums and after your claim has been accepted the premiums are waived.

You can keep this coverage & benefits to the age of 65 or retirement; whichever comes first.

Integration with other sources of income may apply.

This is an own occupation LTD for the first 24 months from the onset of disability.

Benefits are paid to:

Life Insurance – to the beneficiary you have designated
Accidental Death – to the beneficiary you have designated
Accidental Dismemberment – to you
Long Term Disability – to you

For information purposes only. Always refer to the policy for complete and up to date information on your coverage

$500 LTD Bi-weekly *Insurance Premium Option*	$23.40
$750 LTD Bi-weekly *Insurance Premium Option*	$35.98
$1000 LTD Bi-weekly *Insurance Premium Option*	$51.35

For information please contact:
English - Ross Anstis ….. Toll free: 1 866 998 9096
French - Andre Gallant … Toll free: 1 877 299 9940

Desjardins
Financial Security®

200, rue des Commandeurs
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FINANCIAL SERVICES INCLUDING INSURANCE, ANNUITIES, CREDIT AND RELATED SERVICES

GROUP INSURANCE
APPLICATION

ELIGIBILITY REQUIREMENTS

- **Any non-seasonal employee who is in a class indicated in this contract under CLASSES OF EMPLOYEES and who works for the minimum number of hours indicated in the SCHEDULE OF COVERAGE is eligible for coverage under this contract.**
- **Any seasonal emloyee is also eligible for coverage under the contract provided that his employment provides work for at least 8 months out of each 12-month period. In addition, for any such period of 8 months or more, the seasonal employment must provide a minimum of 1200 hours of work or a minimum income of $22 000. The premium must be paid for each month of the year, including those months during which the employee is not at work due to a seasonal interruption.**
- **Any eligible person may submit an application for insurance within 30 days following the date he begins to contribute to the Workers Investment Fund, or at any other time with evidence of insurability.**

1- IDENTIFICATION - PLEASE PRINT

Name of employer	Account No. 140859	Certificat No.
Address - No., street	Sex ☐ M ☐ F / Language ☐ English ☐ French	Date of birth YYYY MM DD
City / Province / Postal code		
Participant's last name / First name	Hours worked during a normal week	Employment status: Permanent: ☐ Full-time ☐ Part-time; Seasonal: ☐ Full-time ☐ Part-time
Address - No., street		
City / Province / Postal code	Occupation	Date of eligibility YYYY MM DD

2- COVERAGES

Life insurance: $10000.00

Accidental Death and Dismemberment: up to a maximum of $10000.00

Long-term Disability - Income: Maximum: ☐ $500 ☐ $750 ☐ $1000 — If no choice is indicated, the minimum coverage according to the contract will apply.

3- BENEFICIARY(IES) - PLEASE PRINT

For the province of Québec: Unless otherwise stipulated, the designation of a legal spouse or spouses joined in a civil union as beneficiary is IRREVOCABLE. Unless otherwise stipulated, the designation of any other person as beneficiary is REVOCABLE.

For all other provinces: This designation of beneficiary is REVOCABLE unless otherwise stipulated.

REVOCABLE: means that the designation of beneficiary can be changed without the beneficiary's consent.

IRREVOCABLE: means that the signature of the irrevocable beneficiary is mandatory to change the beneficiary. The IRREVOCABLE designation of a minor cannot be changed until he or she reaches the majority.

I hereby designate the following person(s) as beneficiary(ies):	Relationship	%	Please check
			☐ REVOCABLE ☐ IRREVOCABLE
			☐ REVOCABLE ☐ IRREVOCABLE
			☐ REVOCABLE ☐ IRREVOCABLE

4- 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 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 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.

5- DECLARATION AND AUTHORIZATION FOR THE COLLECTION AND COMMUNICATION OF PERSONAL INFORMATION

To the best of my knowledge, all the information I have provided on the claim form is accurate and complete. I acknowledge having read the Personal Information Management section. I authorize Desjardins Financial Security Life Assurance Company, strictly for the purposes of managing my file and settling this claim 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, insurance companies; (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 use the personal information it may have about me in existing files that are now closed.

This authorization is also valid for the collection, use and communication of personal information concerning my dependents, insofar as applicable to the claim. A photocopy of this authorization is as valid as the original.

SIGNATURE OF PARTICIPANT: DATE:

ORIGINAL TO POLICYHOLDER – COPY TO PARTICIPANT

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FAX: 506-474-0307