Desjardins Insurance
Life • Health • Retirement

C. P. 3000
Lévis (Québec) G6V 9X8
desjardinslifeinsurance.com/planmember
1-800-263-1810

APPLICATION FOR ENROLLMENT

☐ New application ☐ Reinstatement

Section A. Identification (please print)

Name of policyholder	Group No.	Division No.	Certificate No.
The Free Methodist Church in Canada	542352		

Last name of plan member	First name	Date of birth (YYYY MM DD)	Sex	Language
			☐ M ☐ F	☐ English ☐ French

Address – No., street, apt.	City	Province	Postal code

Annual salary	Class	Date employed on a full-time basis (YYYY MM DD)	Eligibility date (YYYY MM DD)	Number of hours per week

Occupation

Section B. Coverage selection and exemption (benefits available based on whether it's offered as part of your group insurance plan)

Healthcare	Dental care	
☐ Individual	☐ Individual	If you have selected individual coverage for healthcare **AND** dental care, would you like to apply for basic life insurance for your dependents? ☐ Yes ☐ No
☐ Family ☐ Couple* ☐ Single-parent*	☐ Family ☐ Couple* ☐ Single-parent*	When you select family, couple or single-parent coverage for healthcare **OR** dental care, you will automatically have basic life insurance for your dependents. * Select this coverage only if it is offered under your plan. If single-parent and couple coverage aren't offered, your default coverage will be family coverage.
Exemption ☐ Exemption from the healthcare benefit ☐ Exemption from the dental care benefit		You can opt out of coverage for one or both of these benefits. However, to do so, you must already be covered under another similar group insurance plan. If you want to opt out of coverage, would you like to apply for basic life insurance for your dependents if it is offered in your plan? ☐ Yes ☐ No

Section C. Dependent information (continued on the back)

- Complete this section if you selected family, couple or single-parent coverage.
- If you have more than 4 dependent children, use another 9147A form.

SPOUSE

Last name	First name	Date of birth (YYYY MM DD)	Sex
			☐ M ☐ F

☐ Married (YYYY MM DD)
☐ Common-law – Start date of cohabitation:

– Have you had or adopted a child together? ☐ No ☐ Yes (provide details below)

OTHER INSURANCE
☐ No
☐ Yes (specify on the right)

Covered benefits: ☐ Medical care[1] ☐ Paramedical care[1] ☐ Dental care

Coverage: ☐ Individual ☐ Family ☐ Single-parent ☐ Couple

Start date: (YYYY MM DD)

If your spouse is also insured by Desjardins Insurance:[2] Group No.: _____ Certificate No.: _____

1. Care included in the extended healthcare benefit.
2. Desjardins Insurance refers to Desjardins Financial Security Life Assurance Company (DFS).

Section C. Dependent information (continued)

CHILDREN

Last name, first name	Sex M or F	Date of birth YYYY MM DD	Full-time student (ages 18 or 21 and older)[3]	Functionally impaired[4] (ages 18 or 21 and older)[3]	Covered under another group plan
1			☐	☐ YYYY MM DD	☐ Yes (same as spouse) ☐ Yes (other) ☐ No YYYY MM DD
Name of educational institution:[5]			School attendance from:		to:
2			☐	☐ YYYY MM DD	☐ Yes (same as spouse) ☐ Yes (other) ☐ No YYYY MM DD
Name of educational institution:[5]			School attendance from:		to:
3			☐	☐ YYYY MM DD	☐ Yes (same as spouse) ☐ Yes (other) ☐ No YYYY MM DD
Name of educational institution:[5]			School attendance from:		to:
4			☐	☐ YYYY MM DD	☐ Yes (same as spouse) ☐ Yes (other) ☐ No YYYY MM DD
Name of educational institution:[5]			School attendance from:		to:

3. Refer to your policy for eligible ages.

4. A child is considered incapacitated if they are incapable of engaging in any substantially gainful activity and are dependent upon the plan member or the plan member's spouse for financial support and maintenance due to a mental or physical disability. In addition, they must be living with the plan member or the spouse who exercises parental authority or has legal guardianship as if the child were a minor. Please complete the Confirmation of a Dependent Child's Functional Impairment form (09296E) and return it to the address on the form.

5. Information required only for dependents who are full-time students ages 18 or 21 and older (depending on your policy).

Section D. Optional benefits (complete this section to apply for additional benefits offered with your plan)

Please check the provisions of your plan.

- For each benefit, indicate the coverage you want.
- Complete the Evidence of Insurability form (20009A), unless you are selecting the optional accidental death and dismemberment (AD&D) benefit only. IMPORTANT: The Evidence of Insurability form (20009A) must be received by the insurer within 45 days of your application. Otherwise, your application will automatically be cancelled and you will have to resubmit it.
- Québec residents only: Under provincial law, you have 10 days to cancel optional benefits. For full terms and conditions, please see the Notice of Cancellation form (19210E) at desjardinslifeinsurance.com/planmember.

In the last 12 months, have you used any form of tobacco, including electronic cigarettes or other tobacco substitutes?

Plan member: ☐ Yes ☐ No Spouse: ☐ Yes ☐ No

If your plan allows, you can qualify for the non-smoker premium by informing the insurer that you or your spouse have stopped using tobacco for 12 months or more.

Optional life

☐ Plan member _____ No. of units $ _____ OR $ _____ (Fixed amount) OR _____ No. of times the annual salary

☐ Spouse _____ No. of units $ _____ OR $ _____ (Fixed amount)

☐ Each child _____ No. of units $ _____ OR $ _____ (Fixed amount)

Optional AD&D

☐ Plan member _____ No. of units $ _____ OR $ _____ (Fixed amount) OR _____ No. of times the annual salary

☐ Spouse _____ No. of units $ _____ OR $ _____ (Fixed amount)

☐ Each child _____ No. of units $ _____ OR $ _____ (Fixed amount)

Optional critical illness

☐ Plan member _____ No. of units $ _____ OR $ _____ (Fixed amount) OR _____ No. of times the annual salary

☐ Spouse _____ No. of units $ _____ OR $ _____ (Fixed amount)

☐ Each child _____ No. of units $ _____ OR $ _____ (Fixed amount)

Section E. Designation of beneficiaries

Revocable beneficiary: The designation of beneficiary or contingent beneficiary can be changed without the beneficiary's consent.

Irrevocable beneficiary: The signature of the irrevocable beneficiary or contingent beneficiary is mandatory to change the beneficiary. The IRREVOCABLE designation of a minor cannot be changed until they reach the age of majority.

PROVINCE OF QUÉBEC

- The designation of a legally married or civil-union spouse as beneficiary or contingent beneficiary is IRREVOCABLE, unless otherwise stipulated below:

☐ **Revocable designation – I may change this beneficiary designation at any time.**

- The designation of any other person as beneficiary or contingent beneficiary is REVOCABLE. If you want to make their designations irrevocable, use the Request for Designation or Change of Beneficiaries, Contingent Beneficiaries or Trustee form (20007A).

ALL OTHER PROVINCES

- The designation of all beneficiaries or contingent beneficiaries is REVOCABLE. If you want to make their designations irrevocable, use the Request for Designation or Change of Beneficiaries, Contingent Beneficiaries or trustee form (20007A).

BENEFICIARIES

	Last name, first name	Relationship with plan member	%
1		☐ Common-law ☐ Spouse ☐ Child ☐ Friend ☐ Parent ☐ Other:	
2		☐ Common-law ☐ Spouse ☐ Child ☐ Friend ☐ Parent ☐ Other:	
3		☐ Common-law ☐ Spouse ☐ Child ☐ Friend ☐ Parent ☐ Other:	
4		☐ Common-law ☐ Spouse ☐ Child ☐ Friend ☐ Parent ☐ Other:	

CONTINGENT BENEFICIARIES: Designated persons who will receive the benefit if the primary beneficiaries are deceased at the time of payment.

	Last name, first name	Relationship with plan member	%
1		☐ Common-law ☐ Spouse ☐ Child ☐ Friend ☐ Parent ☐ Other:	
2		☐ Common-law ☐ Spouse ☐ Child ☐ Friend ☐ Parent ☐ Other:	

Section F. Designation of trustee – **Does not apply in Québec:** the provisions of the Civil Code apply. DO NOT complete this section.

All other provinces: Complete this section **only** if you have named a minor beneficiary.

The designated trustee will receive in trust for a minor beneficiary any amount under the plan established by Desjardins Insurance. Receipt of these funds by the trustee constitutes a discharge for Desjardins Insurance. A designation is valid until a new trustee is named or until the beneficiary reaches the age of majority, whichever occurs first.

Last name and first name of trustee _____

Section G. Personal information management

To serve you effectively every day and fulfill our legal obligations, we need to collect, use and disclose information about you. You can read Desjardins Group's Privacy Policy at www.desjardins.com/privacy-policy for full details on how your personal information is processed. Specific consents may be required to begin and maintain a business relationship with Desjardins Insurance. These steps will be taken in compliance with Desjardins Group's Privacy Policy. Desjardins Insurance handles your personal information in a confidential manner. Access to your file is limited to authorized personnel who need it to access it to perform their duties. You have the right to review your personal information in our files and correct anything that is incomplete, ambiguous or not relevant. To do so, please consult our Privacy Policy. Desjardins Insurance may use the client list to offer its clients an insurance product following the termination of their group insurance.

Section H. Declaration and authorization for the collection, use and communication of personal information

I certify that all the information provided herein is complete and true. I acknowledge that all the benefits offered in the contract are subject to the provisions for limitations or reductions as well as to the exclusions stipulated therein. I acknowledge that I have read the information on this form and that I have received a copy thereof. In the event of death, I expressly authorize my beneficiary(ies), heir(s) or estate liquidator(s) to provide Desjardins Insurance or its reinsurers with all the information or authorizations deemed necessary to study the claim and obtain the required proofs. This authorization also applies to my minor children, insofar as applicable to this claim. I authorize Desjardins Insurance, its agents and service providers to collect, use and disclose information about me, my spouse or my dependents to any person or organization including the pharmacies, healthcare practitioners, institutions, investigative agencies or insurers for the purposes of underwriting, administration, optimal health management (management claim tools, informative health documentations, etc.), auditing and paying claims. To achieve the purposes described above and to provide you support, your information, on a depersonalized basis, may be used for analysis, statistics and development of predictive models. I authorize my employer to deduct the required premium contributions from my salary. A photocopy of this authorization is as valid as the original.

I acknowledge and accept that this consent takes precedence over any other consent I have previously signed. This consent remains in effect for as long as I maintain a business relationship with Desjardins Group.

By signing this form, I authorize Desjardins Insurance to collect, use and disclose my personal information in accordance with privacy regulations and Desjardins Group's Privacy Policy that was presented to me before signing this consent.

Signature of plan member _____ **Signature of authorized person** _____ **Date** _____

PLAN ADMINISTERED THROUGH THE SECURE SITE FOR PLAN ADMINISTRATORS
Keep the original and give a copy to the plan member.

PLAN ADMINISTERED BY THE INSURER
Send the original to Desjardins Insurance and give a copy to the plan member.

PRINT NEW REQUEST