

Life • Health • Retirement

- FILL OUT THIS STATEMENT ONLY IF:**
- your insurance certificate specifies family, couple or single-parent coverage;
 - you are changing your individual coverage to family, couple or single-parent coverage;
 - you are adding a new eligible dependent.

Proof of registration in an educational institution is required to pay benefits for dependent children aged 18 or older, if all the required information is not provided. Refer to your policy for eligible age.

A IDENTIFICATION – Please print.

Name of policyholder		Group number	Division number
Last name of member	First name	Certificate or identification number	

B IDENTIFICATION OF ELIGIBLE DEPENDENTS – According to the contract.

SPOUSE

Last name	First name	Date of birth YYYY MM DD	Sex <input type="checkbox"/> M <input type="checkbox"/> F
<input type="checkbox"/> Spouse <input type="checkbox"/> Common-law - Start date of cohabitation:		<input type="checkbox"/> No <input type="checkbox"/> Yes - Provide details below.	
Other insurance <input type="checkbox"/> No <input type="checkbox"/> Yes - specify to the right	Covered care or benefit <input type="checkbox"/> Medical care ¹ <input type="checkbox"/> Paramedical care ¹ <input type="checkbox"/> Dental care	Coverage <input type="checkbox"/> Individual <input type="checkbox"/> Family <input type="checkbox"/> Single-parent <input type="checkbox"/> Couple	If your spouse is also insured by Desjardins Insurance* Group no.: _____ Certificate no.: _____

DEPENDENT CHILDREN

1 Last name	First name	Date of birth YYYY MM DD	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Other insurance: <input type="checkbox"/> Same as spouse (above) <input type="checkbox"/> No <input type="checkbox"/> Other			
<input type="checkbox"/> Child with functional impairment ²		YYYY MM DD	YYYY MM DD
<input type="checkbox"/> Child aged 18 or older ³ and full-time student- please specify: Period: From		To	
Name of educational institution:			
2 Last name	First name	Date of birth YYYY MM DD	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Other insurance: <input type="checkbox"/> Same as spouse (above) <input type="checkbox"/> No <input type="checkbox"/> Other			
<input type="checkbox"/> Child with functional impairment ²		YYYY MM DD	YYYY MM DD
<input type="checkbox"/> Child aged 18 or older ³ and full-time student- please specify: Period: From		To	
Name of educational institution:			
3 Last name	First name	Date of birth YYYY MM DD	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Other insurance: <input type="checkbox"/> Same as spouse (above) <input type="checkbox"/> No <input type="checkbox"/> Other			
<input type="checkbox"/> Child with functional impairment ²		YYYY MM DD	YYYY MM DD
<input type="checkbox"/> Child aged 18 or older ³ and full-time student- please specify: Period: From		To	
Name of educational institution:			

- **Note 1: Care included in Extended health care benefit.**
- **Note 2: Please complete Confirmation of a dependent child's functional impairment form no. 09296E and return it to the address shown on the form.**
- **Note 3: Refer to your policy for eligible age.**

* Desjardins Insurance refers to Desjardins Financial Security Life Assurance Company (DFS).

C DECLARATION

I declare that the information above is complete and accurate. I can provide, upon request, proof of eligibility of my dependents (e.g. proof of marriage, cohabitation, birth, adoption, registration in an educational institution).

Signature of member: _____

Date: _____

PLEASE SEND THE ORIGINAL TO DESJARDINS INSURANCE AND KEEP A COPY FOR YOUR FILE.