Desjardins Insurance
Life • Health • Retirement

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desjardinslifeinsurance.com/planmember
Tel.: 1-800-263-1810

GROUP INSURANCE - CONTRACT ADMINISTRATION

MEMBER CHANGE REQUEST

- To ensure approval of adequate coverage, please submit all changes within 31 days of the insurance eligibility date.
- To change a beneficiary, please use form no. 20007A.

A IDENTIFICATION - Please print.

Name of policyholder | Group number | Division number

Last name of member | First name | Certificate number

B CHANGE OF COVERAGE - Please complete sections C or D, if applicable.

Coverage requested

☐ Individual — If your plan allows, would you like to select basic life insurance for your dependents? ☐ Yes ☐ No

☐ Family
☐ Couple
☐ Single-parent

If your plan allows, when you choose one of these coverages, you will automatically have basic life insurance for your dependents.

Event

☐ Marriage or civil union ☐ Termination of the other insurance ☐ Birth or adoption
☐ Start of common-law relationship - Was a child born of this union? ☐ Yes - Please add this child in section C. ☐ No
☐ Other, specify:

Date of the event YYYY MM DD

C IDENTIFICATION OF DEPENDENTS

- Please complete this section if you selected couple, family or single-parent coverage.
- If you have more than 4 dependent children, please use another form no. 04035E or complete Dependent's statement form no. 00291E.

SPOUSE

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

☐ Spouse YYYY MM DD ☐ No
☐ Common-law - Start date of cohabitation: - Was a child born of this union? ☐ Yes - Provide details below.

OTHER INSURANCE: ☐ No ☐ Yes - Please specify the following information:

Covered care or benefit: ☐ Medical care[1] ☐ Paramedical care[1] ☐ Dental care

Coverage: ☐ Individual ☐ Family ☐ Single-parent ☐ Couple | Date of beginning: YYYY MM DD

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 ☐ M ☐ F

Other insurance: ☐ Same as spouse (above) ☐ No ☐ Other

☐ Child with functional impairment[2] YYYY MM DD YYYY MM DD
☐ 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 ☐ M ☐ F

Other insurance: ☐ Same as spouse (above) ☐ No ☐ Other

☐ Child with functional impairment[2] YYYY MM DD YYYY MM DD
☐ 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 ☐ M ☐ F

Other insurance: ☐ Same as spouse (above) ☐ No ☐ Other

☐ Child with functional impairment[2] YYYY MM DD YYYY MM DD
☐ Child aged 18 or older[3] and full-time student- please specify: Period: From To

Name of educational institution:

4 Last name | First name | Date of birth YYYY MM DD | Sex ☐ M ☐ F

Other insurance: ☐ Same as spouse (above) ☐ No ☐ Other

☐ Child with functional impairment[2] YYYY MM DD YYYY MM DD
☐ 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).

PLEASE COMPLETE THE BACK OF THIS FORM.

Desjardins Insurance refers to Desjardins Financial Security Life Assurance Company.

D TERMINATION OF DEPENDENT COVERAGE - Please complete section B if you would like to change your coverage.

I no longer want my plan to cover the following dependents:

Effective date YYYY MM DD

Last name, first name:

Last name, first name:

E REQUEST FOR EXEMPTION OR TERMINATION OF EXEMPTION

Exemption

If my plan allows, I waive coverage under this(these) benefit(s) since I am already covered under another similar group insurance plan: ☐ Extended health care ☐ Dental care

Date of the event YYYY MM DD

Termination of exemption

As I am no longer covered by another similar group insurance plan, I wish to be covered again under this(these) benefit(s): ☐ Extended health care ☐ Dental care

Date of the event YYYY MM DD

Coverage requested

☐ Individual

☐ Family

☐ Couple

☐ Single-parent

If your plan allows, would you like to select basic life insurance for your dependents? ☐ Yes ☐ No

If your plan allows, when you choose one of these coverages, you will automatically have basic life insurance for your dependents.

F OPTIONAL BENEFITS

- **Please check the provisions of your plan.**
- **For each benefit, indicate the coverage you want.**
- **You must complete form no. 20009A – Evidence of insurability unless you are selecting the optional AD&D benefit only.**
  IMPORTANT – The Evidence of insurability form 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 the full terms and conditions please see the form Notice of cancellation no. 19210E at desjardinslifeinsurance.com/planmember.**

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

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

☐ 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 ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D)

☐ 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

☐ 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)

G CANCELLATION OF OPTIONAL BENEFITS

I am cancelling the following optional benefit(s):

Optional life:	☐ Member	☐ Spouse	☐ Dependent children	☐ Dependents (spouse and children)
Accidental death and dismemberment:	☐ Member	☐ Spouse	☐ Dependent children	☐ Dependents (spouse and children)
Critical illness:	☐ Member	☐ Spouse	☐ Dependent children	☐ Dependents (spouse and children)

H

☐ **MATERNITY LEAVE** ☐ **TEMPORARY LAYOFF**
☐ **PARENTAL LEAVE** ☐ **UNPAID LEAVE**

Please check the provisions provided under your plan.

I wish to:

☐ keep the benefits provided by my group insurance plan.

☐ cancel all benefits under my group insurance plan.
excluding the one that includes prescription drug coverage (Québec only).

☐ cancel the disability income insurance under my group insurance plan.

Start date of leave: YYYY MM DD

Expected return to work date: YYYY MM DD

I SIGNATURES

Signature of member **Signature of the authorized person** **Date**

PLAN ADMINISTERED THROUGH THE SECURE SITE FOR PLAN ADMINISTRATORS

Please keep the original and give a copy to the member.

PLAN ADMINISTERED BY THE INSURER

Please send the original to Desjardins Insurance and give a copy to the member.

PRINT **NEW REQUEST**