Desjardins Insurance
Life • Health • Retirement

C. P. 3000
Lévis (Québec) G6V 9X8
desjardinslifeinsurance.com

POLICYHOLDER'S REQUEST FOR CHANGE

To ensure the approval of adequate coverage, please submit all changes within 31 days of the insurance eligibility date. Please use a separate form for each division number affected by modifications.

1. IDENTIFICATION

Name of policyholder	Policy number	Division number

2. CHANGE OF SALARY AND RETURN TO WORK

Certificate number	Last name and first name of employee	CHANGE OF SALARY				RETURN TO WORK			
		New annual salary	Effective date			Return date			New annual salary
			YYYY	MM	DD	YYYY	MM	DD	

3. TERMINATION OF EMPLOYMENT

Certificate number	Last name and first name of employee	Effective date			REASON, specify: (death, dismissal, insufficient number of hours, strike, etc.)
		YYYY	MM	DD	

Signature of policyholder's representative

Date

Desjardins Insurance refers to Desjardins Financial Security Life Assurance Company.

PRINT NEW REQUEST

4. DISABILITY

Certificate number	Last name and first name of disabled employee	Disability started on YYYY	MM	DD	WCB/WSIB/WHSCC	EI CONTRIBUTION	No fault
					☐	☐	☐
					☐	☐	☐
					☐	☐	☐
					☐	☐	☐

5. NAME CHANGE

Certificate number	Previous last name and first name of employee	New name	Reason

6. CHANGE OF DIVISION

Certificate number	Last name and first name of employee	Effective date YYYY	MM	DD	Old division	New division

7. CHANGE OF CLASS

Certificate number	Last name and first name of employee	Effective date YYYY	MM	DD	Old class	New class

8. CHANGE IN PROVINCE OF RESIDENCE

Certificate number	Last name and first name of employee	Effective date YYYY	MM	DD	From	To

9. CHANGE OF ADDRESS OR POLICYHOLDER'S REPRESENTATIVE

☐ **New address** ☐ For billings ☐ For claim cheques

Name of policyholder	Policy number	Division number

No. Street Floor Office / No.

City Province Postal code

☐ **Policyholder's new representative** ☐ For billings ☐ For claim cheques

Name of policyholder	Policy number	Division number

Name of new representative	Telephone	Fax

No. Street Floor Office / No.

City Province Postal code

Signature of policyholder's representative **Date**

PLEASE RETURN THE ORIGINAL TO DESJARDINS INSURANCE.

PRINT **NEW REQUEST**