Desjardins Insurance
Life • Health • Retirement

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GROUP INSURANCE – CONTRACT ADMINISTRATION

REQUEST FOR EXEMPTION OR APPLICATION FOR ENROLLMENT FOLLOWING THE TERMINATION OF EXEMPTION

IDENTIFICATION – THIS SECTION MUST ALWAYS BE COMPLETED.

Name of employer	Contract number	Account number

Last name of participant	First name	Identification or certificate number

A REQUEST FOR EXEMPTION

IDENTIFICATION OF SIMILAR PLAN

Date of life event
YYYY MM DD

Reason of the request or life event: _____

☐ My spouse's plan: last and first names _____

☐ Other plan

Name of employer:

Name of insurer	Contract number	Identification number	Effective date of similar plan coverage YYYY MM DD

I declare that:

The group insurance coverages subscribed by my employer with Desjardins Financial Security Life Assurance Company, hereinafter Desjardins Insurance, were offered to me and explained in detail. Since I am already covered by similar coverages under the above-mentioned group insurance plan, **I choose to renounce the following coverage(s):**

PARTICIPANT AND DEPENDENT(S)

☐ Plan which includes drugs insurance
☐ Supplementary health care plan
☐ Dental care plan

I understand that in order to become eligible for insurance again, I must prove to the satisfaction of the insurer that it has become impossible to remain insured under this plan. I also understand that I may have to establish my insurability or that of my dependents according to contract provisions and at my expense if I apply more than 31 days after the end of the similar plan.

On request, I can provide a copy of the insurance certificate for the similar plan. I certify that the above information is complete and true.

Signature of participant	**Signature of employer's representative**	**Date**

B APPLICATION FOR ENROLLMENT FOLLOWING THE TERMINATION OF EXEMPTION

YYYY MM DD

Date from which it has become impossible for me to remain insured under the plan which justified my exemption: _____

Reason for the termination of the insurance plan: _____

I am applying for insurance again since I am no longer covered under a group insurance plan offering comparable benefits.

On request, I can provide proof that it has become impossible for me to remain insured under the similar plan. I certify that the above information is complete and true.

Signature of participant	**Signature of employer's representative**	**Date**

RETURN A COPY TO YOUR EMPLOYER AND KEEP THE ORIGINAL FOR YOUR RECORDS.

Desjardins Insurance refers to Desjardins Financial Security Life Assurance Company.

PRINT NEW REQUEST