Desjardins Financial Security®
200, rue des Commandeurs
Lévis (Québec) G6V 6R2

FINANCIAL SERVICES INCLUDING INSURANCE, ANNUITIES, CREDIT AND RELATED SERVICES

# EVIDENCE OF INSURABILITY

Attach, if applicable, a copy of the insurance application when submitting this form.

**DENTAL CARE**

ACCOUNT NUMBER

| NAME AND ADDRESS OF PARTICIPANT | NAME AND ADDRESS OF EMPLOYER |
|---|---|
| POSTAL CODE | POSTAL CODE |

| CERTIFICATE NUMBER | IDENTIFICATION NUMBER | OCCUPATION | TELEPHONE NUMBER |
|---|---|---|---|
| – – | | | HOME: AREA CODE + NUMBER WORK: AREA CODE + NUMBER |

| | NAME | DATE OF BIRTH | | NAME | DATE OF BIRTH |
|---|---|---|---|---|---|
| PARTICIPANT | | | CHILDREN | | |
| SPOUSE | | | | | |
| | | | | | |

| ARE ANY OF THE PROPOSED INSUREDS: | PARTICIPANT YES | PARTICIPANT NO | SPOUSE YES | SPOUSE NO | CHILDREN YES | CHILDREN NO |
|---|---|---|---|---|---|---|
| 1- currently receiving dental care or expecting to receive dental care in the next 12 months? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 2- currently suffering from or have any ever suffered from a disease of the mouth, jaw or gums? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

## FOR EACH "YES", PLEASE PROVIDE THE INFORMATION REQUIRED BELOW.

| | PARTICIPANT | SPOUSE | CHILDREN | |
|---|---|---|---|---|
| Annual check-up including cleaning and x-rays | ☐Yes ☐No<br>DATE | ☐Yes ☐No<br>DATE | ☐Yes ☐No<br>DATE | ☐Yes ☐No<br>DATE |
| Extractions<br>If yes, how many? | ☐Yes ☐No<br>HOW MANY?<br>DATE | ☐Yes ☐No<br>HOW MANY?<br>DATE | ☐Yes ☐No<br>HOW MANY?<br>DATE | ☐Yes ☐No<br>HOW MANY?<br>DATE |
| Fillings<br>If yes, how many? | ☐Yes ☐No<br>HOW MANY?<br>DATE | ☐Yes ☐No<br>HOW MANY?<br>DATE | ☐Yes ☐No<br>HOW MANY?<br>DATE | ☐Yes ☐No<br>HOW MANY?<br>DATE |
| Orthodontic services | ☐ Oui ☐ Non<br>HOW MANY?<br>DATE | ☐ Oui ☐ Non<br>HOW MANY?<br>DATE | ☐ Oui ☐ Non<br>HOW MANY?<br>DATE | ☐ Oui ☐ Non<br>HOW MANY?<br>DATE |
| Any other treatment<br>If yes, please specify | ☐ Oui ☐ Non<br>DATE | ☐ Oui ☐ Non<br>DATE | ☐ Oui ☐ Non<br>DATE | ☐ Oui ☐ Non<br>DATE |
| Please provide details for any affirmative answer to question 2, including: diagnosis, treatment, duration, result. | | | | |

### DECLARATION AND AUTHORIZATION WITH RESPECT TO THE COLLECTION AND COMMUNICATION OF PERSONAL INFORMATION

**I authorize Desjardins Financial Security Life Assurance Company, strictly for the purposes of determining my insurability, managing my file and settling my claims to:**

- **collect from any natural person or legal entity, or from any public or parapublic organization, only the information deemed necessary to manage my file. The non-exhaustive list of sources from which informaion may be collected includes health care professionals or facilities, the MIB (formerly known as Medical Information Bureau), insurance companies, personal information officers or investigation agencies, the policyholder, my employer or former employers;**
- **communicate to the said persons or organizations only the personal information about me that is deemed necessary for the purposes of my file;**
- **when necessary, request an inquiry report about me, and also use the personal information it may have about me in existing files that are now closed.**

**This consent applies also to the collection, use and communication of personal information regarding my minor children who are to be insured under this insurance application. A photocopy of this authorization is as valid as the original.**

**I hereby certify that the answers given above are complete and true. I agree that they form an integral part of my application for insurance. I hereby acknowledge that I have read the Personal Information Management section, as well as the notice regarding the MIB and that I have received a copy thereof.**

**The insurance will become effective on the date indicated on the contract. Any false declaration may result in the cancellation of the insurance. If for medical reasons my application for insurance is not accepted as it was submitted, I authorize the medical director to provide the reason for such a decision to my physician.**

**Name and address of physician**

Signature of participant — Signature of spouse — Signature of witness — Date

Signature of dependent children aged 16 and over to be insured (aged 14 and over for Québec)

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 **THE PARTICIPANT MUST RETURN THE ORIGINAL TO DESJARDINS FINANCIAL SECURITY LIFE ASSURANCE COMPANY ALONG WITH HIS APPLICATION AND KEEP THE YELLOW COPY FOR HIS RECORDS**

## PERSONAL INFORMATION MANAGEMENT

Desjardins Financial Security Life Assurance Company (DFS) handles the personal information it has on you in a confidential manner. DFS keeps this information on file so that you may benefit from the Company's various financial services (insurance, annuities, credit, etc.). This information is consulted solely by DFS employees who need to do so in the course of their work.

You have the right to consult your file. You may also have information corrected if you demonstrate that it is inaccurate, incomplete, ambiguous or not useful. To do so, you must send a written request to the following address:

Privacy Officer
Desjardins Financial Security Life Assurance Company
200, rue des Commandeurs
Lévis (Québec) G6V 6R2

DFS may use the client list to offer its client an insurance product following the termination of their group insurance. If you do not wish to receive these offers, you may have your name removed from the list. To do so, you must send a written request to the Privacy Officer at DFS.

## NOTICE REGARDING THE MIB

Information regarding your insurability will be treated as confidential. Desjardins Financial Security Life Assurance Company or its reinsurers may, however, make a brief report thereon to the to the MIB, Inc., formerly known as Medical Information Bureau, a non-profit membership organization of insurance companies, which operates an information exchange on behalf of its member. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 416-597-0590. If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth on its website at www.mib.com. The address of MIB's information office is 330 University Avenue Suite 501, Toronto, Ontario M5G 1R7.

Desjardins Financial Security Life Assurance Company, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.