Desjardins Insurance
Life • Health • Retirement

C. P. 3000
Lévis (Québec) G6V 9X8
Contact us: 1-866-379-7952

FINANCIAL SERVICES INCLUDING INSURANCE, ANNUITIES, CREDIT AND RELATED SERVICES

NOTICE OF RETIREMENT

A IDENTIFICATION

Name of current employer | Transit or division number

Last name of employee | First name | Sex ☐ Male ☐ Female | Date of birth YYYY MM DD

Address – No., street, apartment | Telephone number

City | Province | Postal code | Certificate number

Personal email address | **Official retirement date (after you've taken any leave or vacation that may have accumulated)** | Date of retirement YYYY MM DD

B BENEFITS SELECTION – GROUP INSURANCE PLAN

Your coverage may be temporarily interrupted during the transition from the employee plan to the retiree plan.

BASIC BENEFITS – The premium amount is paid jointly with the employer.

Participant basic life benefit

- According to policy provisions.

Extended health care and dental care benefits

Coverage selection:

☐ Individual (you only)
☐ Couple (you and your spouse)
☐ Single-parent (you and your children)
☐ Family (you, your spouse and your children)
☐ I want to be exempted from these benefits as I am covered by another group insurance plan.

Name of the insurer: _____ Group No.: _____

- The type of coverage will be granted according to the information indicated below and policy provisions.

IDENTIFICATION OF DEPENDENTS – Please refer to your policy for additional information.

By signing this form, I confirm that the persons indicated below meet the definitions of spouse and dependent child found in the policy. If my family situation changes, I must inform Desjardins Insurance*.

Last name and first name	Relation	Sex	Date of birth	Status of dependent: Full-time student (aged 21 to 25 inclusive) or has a functional impairment: Full-time student or has a functional impairment	Name of educational institution
	☐ Spouse ☐ Child	☐ M ☐ F	YYYY MM DD	☐ F. time student YYYY MM DD From ☐ Funct. imp. YYYY MM DD To	
	☐ Spouse ☐ Child	☐ M ☐ F	YYYY MM DD	☐ F. time student YYYY MM DD From ☐ Funct. imp. YYYY MM DD To	
	☐ Spouse ☐ Child	☐ M ☐ F	YYYY MM DD	☐ F. time student YYYY MM DD From ☐ Funct. imp. YYYY MM DD To	

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

OPTIONAL BENEFITS

1- Dependent basic life benefit

- The dependent basic life benefit will be granted according to policy provisions.
- The premium amount is paid jointly with the employer.

☐ I want to keep this benefit.
☐ I do not want to keep this benefit.

For optional benefits 2 to 5, the TOTAL amount of the premium is paid by the participant.

2- Participant optional life benefit

- You can keep this benefit if you are under age 65.
- Minimum $10,000 – maximum $5,000,000 combined with the basic life benefit.

☐ I want to keep this benefit as is.
☐ I want to reduce the coverage amount I have to:
Specify the number of units of $10,000: _____
☐ I do not want to keep this benefit.

3- Participant optional l accidental death and dismemberment benefit (AD&D)

- Available only if you have the participant optional life benefit.
- The amount granted will be the same as what you have selected for the optional life benefit.

☐ I want to keep this benefit.
☐ I do not want to keep this benefit.

4- Spouse optional life benefit

- You can keep this benefit if your spouse is under age 65.
- Minimum $10,000 – maximum $5,000,000

☐ I want to keep this benefit as is.
☐ I want to reduce the coverage amount I have to:
Specify the number of units of $10,000: _____
☐ I do not want to keep this benefit.

5- Spouse optional accidental death and dismemberment benefit (AD&D)

- Available only if you have the spouse optional life benefit.
- The amount granted will be the same as what you have selected for the optional life benefit.

☐ I want to keep this benefit.
☐ I do not want to keep this benefit.

PLEASE COMPLETE THE BACK OF THIS FORM. DON'T FORGET TO SIGN AND DATE SECTIONS C AND D.

Desjardins Insurance refers to Desjardins Financial Security Life Assurance Company.

C DECLARATION AND AUTHORIZATION FOR THE COLLECTION AND COMMUNICATION OF PERSONAL INFORMATION

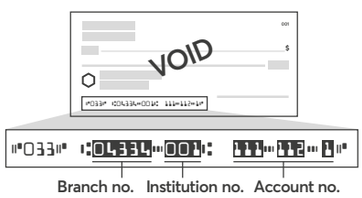
I certify that all the information provided herein is complete and true. I acknowledge that all the benefits offered in the contract are subject to the provisions for limitations or reductions as well as to the exclusions stipulated therein. I acknowledge that I have read the information on this form and that I have received a copy thereof. Strictly for the purposes of managing my file, I authorize Desjardins Insurance to collect from my employer or its mandataries only the personal information it holds concerning me that it needs to process my file. In the event of death, I expressly authorize my beneficiary(ies), heir(s) or estate liquidator(s) to provide Desjardins Insurance, or its reinsurers, with all the information or authorizations deemed necessary to study the claim and obtain the required proofs. This authorization also applies to my minor children, insofar as applicable to this claim. I authorize Desjardins Insurance, its agents and service providers to collect, use and disclose information about me, my spouse or my dependents to any person or organization including the pharmacies, health care practitioners, institutions, investigative agencies or insurers for the purposes of underwriting, administration, optimal health management, auditing and paying claims. A photocopy of this authorization is as valid as the original.

Signature of participant: **Date:**

D PERSONAL PRE-AUTHORIZED DEBIT AGREEMENT (PAD) – PAYOR'S AUTHORIZATION

IMPORTANT

- **The payment of your premiums will be by pre-authorized debit.**
- **Attach a personal cheque marked "VOID" to avoid errors in transcription.**
- **If you change your account or financial institution, please advise Desjardins Insurance at the address of the bottom of the page.**



Last name and first name of account holder(s)	Telephone No.

Name of the financial institution where the account is located	Transit/branch No.	Institution No.	Account No.

WITHDRAWAL AUTHORIZATION

I authorize Desjardins Insurance to make monthly pre-authorized debits (PAD) from my account with the aforementioned financial institution. Each withdrawal will correspond to a variable amount. I will receive pre-notification of this variable amount from Desjardins Insurance, no later than the date the premium is scheduled to be withdrawn. **Consequently, I hereby waive my right to be sent this pre-notification within the 10-day period set out under Payments Canada's Rule H1.**

I further waive my right to receive any pre-notification as long as the withdrawal amount remains the same or when changes are made to my benefits at my request.

I hereby acknowledge having received a copy of this Agreement.

CHANGE OR CANCELLATION

I shall inform Desjardins Insurance, in a timely manner, of any changes to this Agreement. I retain the right to revoke my authorization at any time, with a pre-notification of 30 calendar days. To obtain a sample of the cancellation form or for more information on my right to cancel a PAD Agreement, I may contact my financial institution or visit the Payments Canada website at payments.ca. I agree to release the financial institution of any liability if the revocation is not respected, except in the case of gross negligence on its part. I agree that the financial institution at which I maintain the account is not required to verify that the payment is debited in accordance with this authorization.

I also certify that every person whose signature is required for the operation of the aforementioned account has signed this authorization. I acknowledge that the delivery of this authorization to Desjardins Insurance constitutes delivery by me to the aforementioned financial institution.

REIMBURSEMENT

I have certain recourse rights if any debit does not comply with this Agreement. For example, I have the right to receive reimbursement for any debit that is not authorized or is not consistent with this PAD Agreement. To obtain more information on my recourse rights, I may contact my financial institution or visit payments.ca. The financial institution shall reimburse me, on behalf of the organization, for any amounts withdrawn in error within 90 calendar days, provided that the reimbursement is claimed for a valid reason. I understand that a claim to this effect must be made to my financial institution following the procedure it will provide for that purpose. Finally, I acknowledge that a claim for reimbursement filed after the aforementioned time limits must be settled between me and Desjardins Insurance, without any liability or commitment on the part of my financial institution.

CONSENT TO DISCLOSURE OF INFORMATION

I hereby consent to the disclosure of the information contained in my pre-authorized debit enrollment agreement to the financial institution, provided such information is directly related to and required for the smooth application of the rules governing pre-authorized debits.

Signature of account holder **Date**

Signature of a second account holder (only if two signatures are required) **Date**

E PERSONAL INFORMATION MANAGEMENT

Desjardins Insurance handles the personal information it has on you in a confidential manner. Desjardins Insurance 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 Desjardins Insurance employees who need to do so in the course of their work. Desjardins Insurance may compile anonymized personal information for statistical and informational purposes. Desjardins Insurance may also communicate with plan members to provide them with optimal health management. 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 Insurance, 200, rue des Commandeurs, Lévis, Québec, G6V 6R2. Desjardins Insurance may send information on its promotions or offer new products to those whose names appear on its client list. Desjardins Insurance may also give its client list to another component of the Desjardins Group for the same purposes. 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 Desjardins Insurance.

PLEASE MAKE SURE SECTIONS C AND D ARE SIGNED AND DATED.

Please send the ORIGINAL to Desjardins Insurance, C. P. 3000, Lévis (Québec) G6V 9X8 or by internal mail: LEV 95-2e-J, in a sealed envelope, and keep a COPY for your records.

PRINT NEW REQUEST