Desjardins Insurance
LIFE • HEALTH • RETIREMENT

200, rue des Commandeurs
Lévis (Québec) G6V 6R2

FINANCIAL SERVICES INCLUDING INSURANCE, ANNUITIES, CREDIT AND RELATED SERVICES

CRITICAL ILLNESS CLAIM FORM
INSURED'S STATEMENT

PLEASE READ THE FOLLOWING CAREFULLY BEFORE FILLING IN THE FORM

The diseases for which the insured is covered are stated in the booklet or in the contract; please refer to it.

This statement must be completed by the insured. Should the insured be unable to do so, the form can be completed by the insured's legal representative. Please have form 17026A filled in by the attending physician.

A - INSURED'S IDENTIFICATION - Please print

Insured's usual last name	Last name at birth	First name	Date of birth YYYY MM DD

Address - No., street	City	Province	Postal Code

Telephone Nos.	Home: Area code + number	Work: Area code + number	Ext.

Name of policyowner or first insured	Contract No.	OFFICE USE ONLY Representative No.	F.C. No. or Centre No.

If the claim is submitted on behalf of a dependent, also complete this section:

Last name of dependent	First name	Date of birth YYYY MM DD

Relationship to insured

Address - No., street Check if same as insured: ☐	City	Province	Postal Code

Telephone Nos.	Home: Area code + number	Work: Area code + number	Ext.

B - INFORMATION CONCERNING THE PERSON SUFFERING FROM THE CRITICAL ILLNESS

1. Nature of illness

2. (a) When did symptoms of this illness first appear? YYYY MM DD
   (b) When did this person first consult a physician for this illness? YYYY MM DD
   (c) When was this person first informed of the illness? YYYY MM DD

3. (a) Name and address of this person's family physician
   (b) Name and address of physicians consulted for this illness
   (c) Name and address of hospitals where this person was treated for this illness

4. Has this person consulted a physician or a health care professional or been hospitalized for one or more medical reasons during the 2 years preceding the current illness? ☐ Yes ☐ No **If "Yes"**, complete the table:

Name of treating physicians or health care professionals	Type of illness or injury	Dates of consultations	Name of hospitals where treatment occurred	Hospitalization periods

5. Were any prescribed medications taken during the 2 years prior to the current illness? ☐ Yes ☐ No **If "Yes"**, complete the table:

Illnesses	Name of medication	Periods	
		FROM:	TO:
		FROM:	TO:
		FROM:	TO:

6. Does this person smoke cigarettes, cigarillos, cigars, a pipe, or does she use any other form of tobacco or tobacco substitute such as gum or a nicotine patch? ☐ Yes ☐ No

7. Did she ever use tobacco in any form whatsoever? ☐ Yes ☐ No **If "Yes"**, when did she stop? YYYY MM DD

8. Is there a history of this disease or a similar illness among this person's immediate family members (spouse, son, daughter, father, mother, brother, sister, grandfather, grandmother, uncle, aunt)? ☐ Yes ☐ No **If "Yes"**, complete the table:

Name of the family member	Relationship	Illnesses	Age at onset of illness	Age if still living	Age at death

DECLARATION - I hereby certify that the above answers are complete and true.

SIGNATURE OF THE PERSON SUFFERING FROM THE CRITICAL ILLNESS X　　DATE

If the form was completed by the insured's legal representative:

YOUR SIGNATURE X　　YOUR NAME IN BLOCK LETTERS

YOUR RELATIONSHIP TO INSURED　　DATE

17025A (14-02)

C - AUTHORIZATION TO COLLECT AND COMMUNICATE PERSONAL INFORMATION

For the sole purpose of determining insurability, managing files and processing claims, I authorize Desjardins Financial Security Life Assurance Company (DFS) or its reinsurers: a) to collect from any individual, legal entity or public or parapublic organization only the personal information they have about me that is needed to process my file. This information may be collected from third parties, including any health care professional or establishment, MIB, Inc., insurance and reinsurance companies, personal information brokers, investigation firms, the contract holder, my employer or my former employers; b) to disclose to those individuals, legal entities or public or parapublic organizations only the personal information they have about me that is needed to manage my file; c) to request, if applicable, an investigation report about me and to use the personal information contained in other files it may have that are now closed; d) to disclose to my personal physician any medical information about me that was obtained during the evaluation of my file; e) to disclose to other insurers or reinsurers any information about me that is relevant to determining my eligibility for insurance or for benefits; f) to provide a brief report of my personal health information to MIB, Inc. This authorization also applies to the collection, use and communication of personal information regarding my dependents, insofar as applicable to my claim. A photocopy of this authorization is as valid as the original.

SIGNATURE OF THE PERSON SUFFERING FROM THE CRITICAL ILLNESS (14 YEARS OLD OR OLDER) **OR** THE LEGAL REPRESENTATIVE X　　DATE

AND SIGNATURE OF FATHER, MOTHER OR GUARDIAN IF THIS PERSON IS UNDER THE AGE OF MAJORITY X

Desjardins Insurance refers to Desjardins Financial Security Life Assurance Company.

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 can benefit from the financial services (insurance, annuities, credit, etc.) it offers. 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 can send promotional information or offer new products to individuals whose names appear on its client list. DFS may also give its client list to another component of the Desjardins Group for the same purposes. If you do not want to receive such offers, you may have your name removed from the list by sending a written request to the Privacy Officer at DFS.

DFS uses service providers located outside of Canada to perform certain specific activities in its normal course of business. As such, personal information may be transferred to another country and be subject to the laws of that country. For information about DFS's policies and practices regarding the transfer of personal information outside of Canada, visit the DFS Website at www.desjardinslifeinsurance.com or write to the DFS Privacy Officer at the address indicated above. The Privacy Officer can also answer any questions about the transfer of personal information to service providers located outside of Canada.