

**Submit online:**desjardinslifeinsurance.com/send

Complete and save the form on your computer first.
Keep original forms for your records.

**By mail:**

C. P. 3875 succ. Lévis
Lévis (Québec) G6V 0A7

Send original forms and keep copies
for your records.

**By fax:**

1-844-409-6575 (toll free)
418-835-0194

Keep original forms for your records.

Contact us: 1-800-463-7843 (toll free) or 418-838-7843



Desjardins

Insurance

Life • Health • Retirement

GROUP INSURANCE - DISABILITY CLAIMS

DIRECT DEPOSIT - ENROLLMENT OR CHANGES

DISABILITY CLAIMS

Please include a specimen cheque marked "VOID".

Last name and first name of the member

Certificate or identification no.

Address - No., street, apartment

Policy or group or contract no.

City

Telephone no.

Province

Postal code

()

I hereby authorize Desjardins Financial Security Life Assurance Company, hereinafter Desjardins Insurance, to deposit my benefit payment through the DIRECT DEPOSIT system into account at the financial institution indicated below:

Name of financial institution: _____

Address: _____

Institution no.: _____ **Transit/Branch no.:** _____ **Account no.:** _____

Any credit entered in my account in accordance with this authorization will be identified with a DIRECT DEPOSIT transaction code and I acknowledge that the credit in question shall constitute an amount paid in accordance with this authorization.

This authorization will be effective on _____. The authorization will terminate following a 10-day written notice by either Desjardins Insurance or me.

Signature of member _____ **Date** _____