Lévis (Québec) G6V 9X8

desjardinslifeinsurance.com/planmember

Tel.: 1-800-263-1810

Group insurance - Contract administration DEPENDENT'S STATEMENT

Life · Health · Retirement

FILL OUT THIS STATEMENT ONLY IF:

Α

- your insurance certificate specifies family, couple or single-parent coverage;
- you are changing your individual coverage to family, couple or single-parent coverage;
- you are adding a new eligible dependent.

Proof of registration in an educational institution is required to pay benefits for dependent children aged 18 or older, if all the required information is not provided. Refer to your policy for eligible age.

Last name of member First name Certification number Certification number	IDENTIFICATION - Ple	ease print.						
SPOUSE SPOUSE Service Sist name Sist name Sist name Sist name Sist name Sist name Service Spouse	Name of policyholder		Group nu	Group number		Division number		
Last name First name	Last name of member	t name of member First name			Certificate or identification number			
Spouse	IDENTIFICATION OF ELIGIBLE DEPENDENTS – According to the contract.							
Spouse	SPOUSE							
Same as spouse (above) No Other	Last name	Fil	rst name			MM DD		
Other insurance Covered care or benefit Individual Family Group no.: Certificate no.: Certificat	_ `		YYYY MM DD					
No								
Yes - specify to the right Paramedical care¹ Single-parent Couple Certificate no.:	Other insurance						rance*	
Ves - specify to the right Dental care Depta Dental care D	□ No		Individual Famil	Group n	0.:			
DEPENDENT CHILDREN Last name	Yes - specify to the right	es - specify to the right						
Last name Date of birth NM DD M F								
Other insurance: Same as spouse (above) No Other Child with functional impairment ²		F: .		REN	D C : II	ı	6	
Child with functional impairment2	1 Last name	First nar	ne			MM DD		
Child aged 18 or older³ and full-time student- please specify: Period: From To Name of educational institution: 2 Last name First name Date of birth YYYY MM DD Sex	Other insurance: Same as spouse (above) Other							
Child aged 18 or older3 and full-time student- please specify: Period: From To Name of educational institution: 2	Child with functional impairment ² YYYY MM DD YYYY MM DD YYYY MM DD							
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Date of birth Name of educational institution: Amage of birth Name of educational institution: Child with functional impairment Period: From Period: From Period: From Period: Peri								
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Child with functional impairment2 Child aged 18 or older3 and full-time student- please specify: Period: From To Name of educational institution: 3 Last name First name Date of birth YYYY MM DD Sex MM DD Sex MM DD MM F Other insurance: Same as spouse (above) No Other Child with functional impairment2 Child with functional impairment2 To Name of educational institution: Note 1: Care included in Extended health care benefit. Note 2: Please complete Confirmation of a dependent child's functional impairment form no. 09296E and return it to the address shown on the form. Note 3: Refer to your policy for eligible age. * Desjardins Insurance refers to Desjardins Financial Security Life Assurance Company (DFS).	2 Last name First name					MM DD		
Child aged 18 or older ³ and full-time student- please specify: Period: From Name of educational institution: Date of birth	Other insurance: Same as spouse (above) Other							
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	* Desjardins Insurance refers DECLARATION	to Desjardins Financial Security	Life Assurance Company (DFS).					

I declare that the information above is complete and accurate. I can provide, upon request, proof of eligibility of my dependents (e.g. proof of marriage, cohabitation, birth, adoption, registration in an educational institution).

Signature of member: Date: