Desjardins Insurance
Life • Health • Retirement

FMSQ

INSURANCE APPLICATION

A group insurance plan insured by Desjardins Financial Security Life Assurance Company, hereinafter Desjardins Insurance, and administered by:

Sogemec ASSURANCES
Financial Services Firm

DRUG, HEALTH AND DENTAL CARE INSURANCE

A IDENTIFICATION

Last name	Certificate no.	Date of birth YYYY MM DD
First name	Sex ☐ M ☐ F	Language ☐ English ☐ French
Address - No., street ☐ Home ☐ Office	Telephone nos. Office: ( )	
City / Province / Postal code	Home: ( )	
Member no. / Effective date of insurance YYYY MM DD	E-mail address	

Specialty

B BENEFITS SELECTION – PARTICIPANTS UNDER AGE 65.

- **All the benefits offered are subject to the limitation and/or reduction clauses, as well as to the exclusions stipulated in the contract.**
- **Québec residents only: Under provincial law, you have 10 days to cancel optional benefits. For the full terms and conditions please see the form Notice of cancellation no. 19210E at desjardinslifeinsurance.com/planmember.**

BENEFIT H – DRUG AND HEALTH INSURANCE – The option selected is valid for a minimum of 2 years.

☐ OPTION 1 – DRUG INSURANCE	☐ OPTION 2 – DRUG AND HEALTH INSURANCE	☐ OPTION 3 – DRUG INSURANCE RAMQ LIST
Deductible: • $100 - individual and single-parent • $200 - couple and family Coinsurance: • 75% Maximum payment per adult: • According to RAMQ maximum amount Benefit: • Prescription drugs • Travel and cancellation insurance	Deductible: • $200 - individual and single-parent • $400 - couple and family Coinsurance - drugs: • 80% Maximum payment per adult: • According to RAMQ maximum amount Coassurance - medical and paramedical expenses: • 80% of eligible expenses Benefit: • Prescription drugs • Travel and cancellation insurance • Medical and paramedical insurance	Deductible: • $150 - individual and single-parent • $300 - couple and family Coinsurance: • 66% Maximum payment per adult: • According to RAMQ maximum amount Benefit: • Drugs - RAMQ list

Evidence of insurability may be required – Please see section C.

☐ **BENEFIT I – DENTAL CARE INSURANCE**

Benefit is optional but conditional to enrollment in option 2. Election of this benefit is effective for a minimum of 3 years.
Dental expenses incurred during the first six months of insurance are not reimbursed if enrollment for this benefit is received by the insurer 180 days following your eligibility date.

Deductible: $100	Coinsurance: 100% - Basic and preventive care 80% - Minor restoration 50% - Major restoration Maximum per calendar year: $1,500 per insured for all benefits described to the left combined	Coinsurance: 50% - Orthodontics Lifetime maximum: $1,500 per insured

Check selected or changed coverage: ☐ Individual ☐ Single-parent ☐ Couple ☐ Family

In the case of a change in coverage:

Event justifying the change (marriage, birth, divorce, etc.):

Date of the event: YYYY MM DD

C GROUP INSURANCE PLAN TRANSFER

☐ TERMINATION OF EXEMPTION ☐ TRANSFER FROM ANOTHER ASSOCIATION GROUP'S GROUP INSURANCE PLAN

You must complete the evidence of insurability form no. 20009A.

Termination date YYYY MM DD	Reason for termination	Name of former insurer	Contract no.

D INFORMATION ON DEPENDENTS – Complete if you selected single-parent, couple or family coverage.

Last name, first name	Sex F - M	Relationship with participant (spouse, child)	Date of birth YYYY	MM	DD	Dependent status S = 21 to 25 years, full-time student X = Functional impairment	Name of insurer if other health insurance benefit

Desjardins Insurance refers to Desjardins Financial Security Life Assurance Company.

E PAYMENT METHOD – Please select one option only: 1, 2 or 3.

☐ OPTION 1: MONTHLY PRE-AUTHORIZED CHEQUING (PAC) PAYMENTS

Payments will be automatically debited each month from the account below.

Type of services: ☐ Personal ☐ Business **Please enclose a sample cheque marked "VOID".**

Name of account holder	Name of the financial institution	Bank account number
Full address of the financial institution		Transit number

Type of account: ☐ Personal chequing ☐ Chequing/Savings ☐ Direct deposit account ☐ Other

Joint accounts: Is this a joint account requiring only one signature? ☐ Yes ☐ No

If more than one signature is required on withdrawals issued against the account, both account holders must sign this authorization.

I/We authorize Sogemec Assurances inc. to withdraw the premium amount of $ ______________ from my/our bank account for monthly insurance premiums due on or after the date I/we sign this authorization. I/We authorize Sogemec Assurances inc. to withdraw premiums on or about the first business day of each month or the next business day thereafter. Withdrawals from my/our account may be for variable amounts and may change in accordance with the insurance contract and as required to administer the policy. I/We waive the right to receive 10 days' notice of the amount and date of each automatic withdrawal from my/our account. If my/our bank or financial institution does not honour an automatic monthly withdrawal the first time it is presented for payment, Sogemec Assurances inc. may attempt to withdraw that payment again within 30 days. Sogemec Assurances inc. reserves the right to ask me/us for an alternate method of payment if my/our payment is not honoured. All one-time or automatic withdrawals from my/our bank account will be treated as personal withdrawals as defined by Payments Canada's Rule H1. I/We and/or Sogemec Assurances inc. can end this agreement at any time by giving 10 days' written notice. I/We understand that cancelling this PAD agreement may result in a loss of insurance coverage unless Sogemec Assurances inc. receives another form of payment.

You may obtain a sample cancellation form by contacting your financial institution or through payments.ca. If you have any questions about withdrawals from your bank account, contact us at 1-800-361-5303, information@sogemec.qc.ca or write to us at Sogemec Assurances inc., C. P. 217, Succ. Desjardins, Montréal, Québec, H5B 1G9. You have certain recourse rights if any debit does not comply with this agreement. For example, you have the right to receive reimbursement for any PAD withdrawal that is not authorized or is inconsistent with this PAD agreement. To obtain a form for a reimbursement claim, or for more information on your recourse rights, you may contact your financial institution or visit payments.ca.

Name of account holder (PLEASE PRINT)	**Signature of account holder**
Second signature of account holder if joint account	**Date**

☐ OPTION 2: YEARLY CHEQUE PAYMENTS

Type of services: ☐ Personal ☐ Business

Please enclose a cheque payable to Sogemec Assurances inc.

☐ OPTION 3: CREDIT CARD PAYMENTS

Please register your credit card payment by visiting the secure website of Sogemec Assurances
https://www.sogemec.qc.ca/en/spec/form/medecin-specialiste-formulaires-autorisation.html

F DECLARATION AND AUTHORIZATION FOR THE COLLECTION AND COMMUNICATION OF PERSONNEL INFORMATION

I certify that all the information contained on this application form is complete and true. I acknowledge that the coverages offered are subject to the limitation and/or reduction clauses, as well as to the exclusions stipulated in the contract. I acknowledge that I have read the information on this form and that I have kept a copy thereof. 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, auditing and paying claims. A photocopy of this authorization is as valid as the original.

ATTENTION : Signatures are only required below if a financial security advisor has enrolled the participant.

Name (PLEASE PRINT) and signature of financial security advisor ☐ Check if trainee Date

Name (PLEASE PRINT) and signature of training supervisor

G PERSONAL INFORMATION MANAGEMENT

Desjardins Insurance and Sogemec Assurances inc. (Sogemec) handle the personal information they have on you in a confidential manner. Desjardins Insurance and Sogemec keep this information on file so that you may benefit from group insurance services they offer. This information is consulted solely by Desjardins Insurance and Sogemec employees who need to do so in the course of their work. Desjardins Insurance may compile anonymized personal information for statistical and informational purposes. You have the right to consult your file at Desjardins Insurance and at Sogemec. 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 one of the following addresses:

Privacy Officer
Desjardins Insurance
200, rue des Commandeurs
Lévis (Québec) G6V 6R2

Sogemec Assurances inc.
2, Complexe Desjardins, Tour de l'est, 20e étage
C. P. 217, Succ. Desjardins
Montréal (Québec) H5B 1G9

Desjardins Insurance and Sogemec may use their client list to offer their clients 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 lists. To do so, you must send a written request to the Privacy Officer at Desjardins Insurance or to Sogemec.

Please send this document to Sogemec Assurances inc.
https://www.sogemec.qc.ca/formulaire-depot-de-fichier-securise.html