Desjardins Insurance
Life • Health • Retirement

C. P. 3000
Lévis (Québec) G6V 9X8
desjardins.com/planmember
1-800-263-1810

PLAN MEMBER CHANGE REQUEST

- To ensure approval of adequate coverage, submit all changes within 31 days of the insurance eligibility date.
- Use form No. 20007A to make a change to a beneficiary.

Section A. Identification (Please print.)

Name of policyholder	Group number	Division number

Last name of plan member	First name	Certificate number

Section B. Change of coverage (Complete sections C or D, if applicable.)

Coverage requested – Benefits available based on whether it's offered as part of your group insurance plan.

Healthcare	Dental care	
☐ Individual	☐ Individual	If you select individual coverage for healthcare **AND** dental care, would you also like to apply for basic life insurance for your dependents? ☐ Yes ☐ No
☐ Family ☐ Couple* ☐ Single-parent*	☐ Family ☐ Couple* ☐ Single-parent*	When you select family, couple or single-parent coverage for healthcare **OR** dental care, you will automatically have basic life insurance for your dependents. * Select this coverage only if it is offered under your plan. Otherwise, family coverage will be chosen by default.

Event — **Date of the event** (YYYY MM DD)

☐ Marriage or civil union ☐ Termination of the other insurance ☐ Birth or adoption

☐ Start of common-law relationship – Have you had or adopted a child together? ☐ Yes – Add this child in section C. ☐ No

☐ Other, specify _____

Section C. Dependent information

- Please complete this section if you selected couple, family or single-parent coverage.
- If you have more than 4 dependent children, use another 04035E form.

SPOUSE

Last name	First name	Date of birth (YYYY MM DD)	Sex
			☐ M ☐ F

☐ Married (YYYY MM DD)

☐ Common-law – Start date of cohabitation: – Have you had or adopted a child together? ☐ Yes ☐ No

OTHER INSURANCE
☐ No
☐ Yes (specify on the right)

Covered benefits ☐ Medical care[1] ☐ Paramedical care[1] ☐ Dental care

Coverage ☐ Individual ☐ Family ☐ Single-parent ☐ Couple — Start date: (YYYY MM DD)

If your spouse is also insured by Desjardins Insurance:[2] Group No. _____ Certificate No. _____

CHILDREN

	Last name, first name	Sex M or F	Date of birth (YYYY MM DD)	Full-time student (ages 18 and older or 21 and older)[3]	Functionally impaired[4] (ages 18 and older or 21 and older)[3]	Covered under another group plan
1				☐	☐	☐ Yes (same as spouse) ☐ Yes (other) ☐ No
	Name of educational institution[5]		School attendance from (YYYY MM DD)		to (YYYY MM DD)	
2				☐	☐	☐ Yes (same as spouse) ☐ Yes (other) ☐ No
	Name of educational institution[5]		School attendance from (YYYY MM DD)		to (YYYY MM DD)	
3				☐	☐	☐ Yes (same as spouse) ☐ Yes (other) ☐ No
	Name of educational institution[5]		School attendance from (YYYY MM DD)		to (YYYY MM DD)	
4				☐	☐	☐ Yes (same as spouse) ☐ Yes (other) ☐ No
	Name of educational institution[5]		School attendance from (YYYY MM DD)		to (YYYY MM DD)	

1. Care included in the extended healthcare benefit.
2. Desjardins Insurance refers to Desjardins Financial Security Life Assurance Company (DFS).
3. Refer to your policy for eligible ages.
4. A child is considered incapacitated if they are incapable of engaging in any substantially gainful activity and are dependent upon the plan member or the plan member's spouse for financial support and maintenance due to a mental or physical disability. In addition, they must be living with the plan member or the spouse who exercises parental authority or has legal guardianship as if the child were a minor. Please complete the Confirmation of a Dependent Child's Functional Impairment form (09296E) and return it to the address on the form.
5. Information required only for dependents who are full-time students ages 18 and older or 21 and older (depending on your policy).

Section D. Termination of dependent coverage (Complete section B if you would like to change your coverage.)

I no longer want my plan to cover the following dependents:

Effective date YYYY MM DD

Last name, first name:

Last name, first name:

Section E. Request for exemption or termination of exemption

Exemption

If my plan allows, I **WAIVE** coverage under these benefits since I am already covered under another similar group insurance plan:

☐ Extended healthcare ☐ Dental care

Date of the event YYYY MM DD

Termination of exemption

☐ I ask that my benefits be reinstated, as I am no longer covered by another group insurance plan.
Complete section B to choose your coverage.

Date of the event YYYY MM DD

Section F. Optional benefits (Benefits available based on whether it's offered as part of your group insurance plan.)

- Check the provisions of your plan.
- For each benefit, indicate the coverage you want.
- You must complete form No. 20009A – Evidence of insurability unless you are selecting the optional accidental death and dismemberment (AD&D) benefit only. IMPORTANT – The Evidence of insurability form must be received by the insurer within 45 days of your application. Otherwise, your application will automatically be cancelled and you will have to resubmit it.
- 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 form (19210E) at desjardins.com/planmember.

In the last 12 months, have you used any form of tobacco, including electronic cigarettes or other tobacco substitutes?

Plan member ☐ Yes ☐ No Spouse ☐ Yes ☐ No

If your plan allows, you can qualify for the non-smoker premium by informing the insurer that you or your spouse has stopped using tobacco for 12 months or more.

Optional life

☐ Plan member _____ No. of units $ _____ OR $ _____ (Fixed amount) OR _____ No. of times the annual salary

☐ Spouse _____ No. of units $ _____ OR $ _____ (Fixed amount)

☐ Each child _____ No. of units $ _____ OR $ _____ (Fixed amount)

Optional accidental death and dismemberment (AD&D)

☐ Plan member _____ No. of units $ _____ OR $ _____ (Fixed amount) OR _____ No. of times the annual salary

☐ Spouse _____ No. of units $ _____ OR $ _____ (Fixed amount)

☐ Each child _____ No. of units $ _____ OR $ _____ (Fixed amount)

Optional critical illness

☐ Plan member _____ No. of units $ _____ OR $ _____ (Fixed amount) OR _____ No. of times the annual salary

☐ Spouse _____ No. of units $ _____ OR $ _____ (Fixed amount)

☐ Each child _____ No. of units $ _____ OR $ _____ (Fixed amount)

Section G. Cancellation of optional benefits

I am cancelling the following optional benefits:

Optional life	☐ Plan member	☐ Spouse	☐ Dependent children	☐ Dependents (spouse and children)
Accidental death and dismemberment	☐ Plan member	☐ Spouse	☐ Dependent children	☐ Dependents (spouse and children)
Critical illness	☐ Plan member	☐ Spouse	☐ Dependent children	☐ Dependents (spouse and children)

Section H. Type of absence

☐ **Maternity leave** ☐ **Parental leave** ☐ **Unpaid leave** ☐ **Temporary layoff**

Please check the provisions provided under your plan.

I wish to:

☐ keep the benefits provided by my group insurance plan.

☐ cancel all benefits under my group insurance plan.
excluding the one that includes prescription drug coverage (Québec only).

☐ cancel the disability income insurance under my group insurance plan.

Start date of leave YYYY MM DD _____ Expected return to work date YYYY MM DD _____

Section I. Signatures

Signature of plan member **Signature of the authorized person** **Date**

PLAN ADMINISTERED THROUGH THE SECURE SITE FOR PLAN ADMINISTRATORS

Please keep the original and give a copy to the plan member.

PLAN ADMINISTERED BY THE INSURER

Please send the original to Desjardins Insurance and give a copy to the plan member.

PRINT **NEW REQUEST**