Desjardins Insurance
Life • Health • Retirement

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

EVIDENCE OF INSURABILITY
DENTAL CARE

Attach a copy of the insurance application when submiting this form.

IDENTIFICATION

Last name and first name of member	Group or contract No.	Division No.	Certificate No.

Address of member – No., street, apt.	City	Province	Postal code

Telephone numbers Home: Work:	Occupation

Name of employer (or group or policyholder)

Address – No., street, suite	City	Province	Postal code

IDENTIFICATION OF PROPOSED INSUREDS

	Last name, first name	Date of birth (YYYY-MM-DD)		Last name, first name	Date of birth (YYYY-MM-DD)
MEMBER			**CHILDREN**		
SPOUSE					

Are any of the proposed insureds:	MEMBER		SPOUSE		CHILDREN	
	YES	NO	YES	NO	YES	NO
1. currently receiving dental care?	☐	☐	☐	☐	☐	☐
2. expecting to receive dental care in the next 12 months?	☐	☐	☐	☐	☐	☐
3. currently suffering from a disease of the mouth, jaw or gums?	☐	☐	☐	☐	☐	☐
4. have ever suffered from a disease of the mouth, jaw or gums?	☐	☐	☐	☐	☐	☐

For each "YES", please provide the information required below:

	MEMBER	SPOUSE	CHILDREN	
Annual check-up including cleaning and x-rays	☐ Yes ☐ No Date _____	☐ Yes ☐ No Date _____	☐ Yes ☐ No First name _____ Date _____	☐ Yes ☐ No First name _____ Date _____
Extractions If yes, how many?	☐ Yes ☐ No How many? _____ Date _____	☐ Yes ☐ No How many? _____ Date _____	☐ Yes ☐ No-How many?_____ First name _____ Date _____	☐ Yes ☐ No-How many?_____ First name _____ Date _____
Fillings If yes, how many?	☐ Yes ☐ No How many? _____ Date _____	☐ Yes ☐ No How many? _____ Date _____	☐ Yes ☐ No-How many?_____ First name _____ Date _____	☐ Yes ☐ No-How many?_____ First name _____ Date _____
Orthodontic services	☐ Yes ☐ No How many?_____ Date _____	☐ Yes ☐ No How many? _____ Date _____	☐ Yes ☐ No-How many?_____ First name _____ Date _____	☐ Yes ☐ No How many?_____ First name _____ Date _____

PLEASE COMPLETE THE BACK OF THIS FORM.

	MEMBER	SPOUSE	CHILDREN	
Any other treatment If yes, please specify:	☐ Yes ☐ No Date _____	☐ Yes ☐ No Date _____	☐ Yes ☐ No First name _____ Date _____	☐ Yes ☐ No First name _____ Date _____
Please specify any affirmative answers to questions 3 and 4: diagnosis, treatment, duration and outcome			First name _____	First name _____

STATEMENT AND AUTHORIZATION OF PERSONAL INFORMATION

I hereby certify that the answers given above are complete and true and I agree that they form an integral part of my application for insurance. I hereby acknowledge that I have read the notice regarding personal information management, as well as the notice regarding the MIB, LLC and that I have received a copy thereof. The insurance will become effective on the date indicated on the contract. Any false declaration may result in the cancellation of the insurance.For the sole purpose of determining insurability, managing files and processing claims, I authorize Desjardins Insurance 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, LLC, 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 on my personal information, including my health information, to MIB, LLC. To achieve the purposes described above and to provide you support, your information, on a depersonalized basis, may be used for analysis, statistics and development of predictive models. 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. If the Desjardins Insurance medical director deems appropriate, I authorize the medical director to send the information that they obtained to analyze my application or that supports the Company's decision to the following physician:

Name and address of physician _____

Signature of member _____ **Signature of spouse** _____ **Date** _____

Signature of dependent children aged 18 and over to be insured (aged 14 and over for Québec) _____

PERSONAL INFORMATION MANAGEMENT

To serve you effectively every day and fulfill our legal obligations, we need to collect, use and disclose information about you. You can read Desjardins Group's Privacy Policy at www.desjardins.com/privacy-policy for full details on how your personal information is processed. Specific consents may be required to begin and maintain a business relationship with Desjardins Insurance. These steps will be taken in compliance with Desjardins Group's Privacy Policy. Desjardins Insurance handles the personal information it has on you in a confidential manner. Access to your file is limited to authorized personnel who need it to access it to perform their duties. Desjardins Insurance may also communicate with plan members to provide them with optimal health management (management claim tools, informative health documentations, etc.) and offer its clients an insurance product following the termination of their group insurance. You have the right to review your personal information in our files and correct anything that is incomplete, ambiguous or not relevant. To do so, please consult our Privacy Policy.

NOTICE APPLICABLE TO MIB, LLC

Information regarding the insurability of the person to be insured will be treated as confidential by Desjardins Insurance, its reinsurers and MIB, LLC, a not-for-profit membership organization of insurance companies that operates an information exchange on behalf of its members. If you submit an application for life or health insurance coverage for an individual or a benefit claim for an insured to another MIB, LLC member company, upon request, MIB, LLC will supply such company with the information it has on file about this person.

MIB, LLC receives personal information for which the collection, use and disclosure is governed by the Personal Information Protection and Electronic Documents Act (PIPEDA) and provincial laws. Accordingly, MIB, LLC has agreed to protect such information in a manner that is substantially similar to Desjardins Insurance's privacy and personal information protection practices and in accordance with applicable laws. As a U.S.-based company, MIB, LLC is also bound by U.S. laws regarding the disclosure of personal information. To review MIB's Consumer Privacy Policy, please visit www.mib.com/privacy_policy.html.

Upon request, MIB, LLC will disclose all of the information in an insured's file to that insured. Insureds can contact MIB, LLC by emailing canadadisclosure@mib.com or calling 1-866-692-6901. Insureds who dispute the accuracy of the information MIB, LLC has on record for them can seek a correction in accordance with the procedures set forth on MIB, LLC's website at www.mib.com. They can also write to MIB, LLC's information office at 50 Braintree Hill Park, Suite 400, Braintree MA 02184-8734.

Desjardins Insurance and its reinsurers can also release information from their files to other insurance companies to which an application for life or health insurance or a benefit claim has been submitted. Consumers can obtain additional information about MIB, LLC at www.mib.com.

Return the original of this form to Desjardins Insurance with a copy of the insurance application.
Keep a copy for your records.
Desjardins Insurance, C. P. 3000, Lévis (Québec) G6V 9X8

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