

## APPLICATION FOR ENROLLMENT

**ONA DENTAL PLAN FOR EARLY RETIREES  
(AGES 60-64) CONTRACT NO. 542300**

### A IDENTIFICATION - Please print.

Last name		First name	
Address- No., street, apt.		City	Province
		Postal code	
Telephone number	E-mail address	Date of birth YYYY MM DD	Sex <input type="checkbox"/> M <input type="checkbox"/> F
		Language <input type="checkbox"/> E <input type="checkbox"/> F	
Retirement date YYYY MM DD	Last employer	Former contract number	

### B DENTAL CARE BENEFIT

All the benefits offered in the policy are subject to the provisions for limitations or reductions as well as to the exclusions stipulated therein.

If you select family coverage, please complete section C below.

Individual coverage (without dependents)  Family coverage (with dependents)

### C IDENTIFICATION OF DEPENDENTS - Please complete this section if you selected family coverage.

If you have more than 2 dependent children, please use another form no. 08039E or complete Dependent's statement form no. 00291E.

#### SPOUSE

Last name		First name		Date of birth YYYY MM DD	Sex <input type="checkbox"/> M <input type="checkbox"/> F
<input type="checkbox"/> Spouse		YYYY MM DD		<input type="checkbox"/> No	
<input type="checkbox"/> Common-law - Start date of cohabitation:				- Was a child born of this union? <input type="checkbox"/> Yes - Provide details below.	
Other insurance <input type="checkbox"/> No <input type="checkbox"/> Yes - specify to the right.	Covered care or benefit <input type="checkbox"/> Medical care <sup>1</sup> <input type="checkbox"/> Paramedical care <sup>1</sup> <input type="checkbox"/> Dental care	Coverage <input type="checkbox"/> Individual <input type="checkbox"/> Family <input type="checkbox"/> Single-parent <input type="checkbox"/> Couple	If your spouse is also insured by Desjardins Insurance Group no.: _____ Certificate no.: _____		

#### DEPENDENT CHILDREN

<b>1</b>	Last name	First name	Date of birth YYYY MM DD	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Other insurance: <input type="checkbox"/> Same as spouse (above) <input type="checkbox"/> No <input type="checkbox"/> Other				
<input type="checkbox"/> Child with functional impairment <sup>2</sup> YYYY MM DD YYYY MM DD				
<input type="checkbox"/> Child aged 18 or older <sup>3</sup> and full-time student - please specify: Period: From To				
Name of educational institution: _____				
<b>2</b>	Last name	First name	Date of birth YYYY MM DD	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Other insurance: <input type="checkbox"/> Same as spouse (above) <input type="checkbox"/> No <input type="checkbox"/> Other				
<input type="checkbox"/> Child with functional impairment <sup>2</sup> YYYY MM DD YYYY MM DD				
<input type="checkbox"/> Child aged 18 or older <sup>3</sup> and full-time student - please specify: Period: From To				
Name of educational institution: _____				

• Note 1: Care included in Extended health care benefit.

• Note 3: Refer to your policy for eligible age.

• 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.

### D PERSONAL PRE-AUTHORIZED DEBITS

Please fill out form no. 09239E - Application for enrollment - Personal pre-authorized debits form, and include it with your application.

### E DECLARATION

I certify that all the information provided herein is complete and true. I acknowledge that all the benefits offered in the policy are subject to the provisions for limitations or reductions as well as to the exclusions stipulated therein. I acknowledge that I have read and received a copy of the Personal Information Management section at the back of this form.

Signature of retiree: \_\_\_\_\_

Date: \_\_\_\_\_

FOR INSURER USE ONLY

Please return the original to Desjardins Insurance and keep a copy for your file.

08039E (2019-05)

Desjardins Insurance refers to Desjardins Financial Security Life Assurance Company.

Documents sent on:		
YYYY	MM	DD

## PERSONAL INFORMATION MANAGEMENT

Desjardins Insurance handles the personal information it has on you in a confidential manner. Desjardins Insurance keeps this information on file so that you may benefit from group insurance services offered by the Company. This information is consulted solely by Desjardins Insurance employees who need to do so in the course of their work. Desjardins Insurance may compile anonymized personal information for statistical and informational purposes. Desjardins Insurance may also communicate with plan members to provide them with optimal health management.

You have the right to consult your file. 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 the following address:

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

Desjardins Insurance may use the client list to offer its 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 list. To do so, you must send a written request to the Privacy Officer at Desjardins Insurance.