

SIMPLIFIED OFFER APPLICATION

LIFE AND CRITICAL ILLNESS INSURANCE

Your insurance policy enables you to receive a simplified offer for \$250,000 of life insurance and/or critical illness insurance without having to provide any medical evidence. This offer ends February 26th, 2016.

With this offer, John Taylor could qualify for life insurance and/or critical illness insurance in three simple steps:

To the attention of the policyowner of policy
123456

- 1 Provide the information on the product applied for and the beneficiaries.
- 2 The insured must answer the insurability questions below.
- 3 Sign where indicated.

Information on your policy 123456

Policyowner John Taylor

Insured John Taylor

Client Insured number 654321

Information on the product applied for

Premium calculated* on December 1st, 2015 based on an insurance amount of \$250,000. Please select one product only.

Life Insurance							
Term Life	(\$ Monthly)	(\$ Annual)	Code	Whole Life	(\$ Monthly)	(\$ Annual)	Code
<input type="checkbox"/> Term 10	17.10	190.00	T10-K	<input type="checkbox"/> Life 10	471.38	5,237.50	WL10-H STB1 : G3
<input type="checkbox"/> Term 20	24.98	277.50	T20I-K	<input type="checkbox"/> Life 20	255.38	2,837.50	WL20I-K STB1 : G3
<input type="checkbox"/> Term 30	39.38	437.50	T30I-C	<input type="checkbox"/> Life at 65	220.05	2,445.00	WL 65I-B STB1 : G3
<input type="checkbox"/> MAXLife (T100)	161.55	1,795.00	T100I-W STB1 : G5	<input type="checkbox"/> Guaranteed Whole Life	171.90	1,910.00	WL CI-H STB1 : G3
Critical Illness							
<input type="checkbox"/> Harmony T10	77.85	865.00	Q10R-D	<input type="checkbox"/> Harmony T20	113.63	1,262.50	Q20R-D

*If the Insured's age on the nearest birthday changes on December 1st, 2015, the premiums indicated above are no longer valid.

OR other products

Life and/or Critical Illness Insurance

Premium \$

Insurance Amount \$

Monthly Annual

Please attach the illustration. Total life and critical illness insurance amounts must be less than or equal to \$250,000.

Information on beneficiaries

Beneficiaries	First and last name	Date of birth	Sex	Relationship to Insured	Status
Upon death		YYYY MM DD	<input type="checkbox"/> F <input type="checkbox"/> M		<input type="checkbox"/> Revocable <input type="checkbox"/> Irrevocable
Contingent		YYYY MM DD	<input type="checkbox"/> F <input type="checkbox"/> M		<input type="checkbox"/> Revocable <input type="checkbox"/> Irrevocable

Life and Critical Illness Insurance - Insurability Questionnaire for the Insured

In the last 5 years	Have you had any insurance coverage declined, approved with an extra premium or with restrictions?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you been diagnosed, or treated for, coronary artery disease, heart attack, cerebrovascular accident (CVA) or transient ischemic attack (TIA), cancer, diabetes or HIV?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you used tobacco (cigarettes, cigarillos, cigars or a pipe), marijuana, or any other type of tobacco products or substitutes such as nicotine gum, electronic cigarettes, nicotine patches or anti-smoking medication?	<input type="checkbox"/> Yes <input type="checkbox"/> No
In the last 2 years	Have you been unable to work or do your usual activities for more than 30 consecutive days because of an injury or illness?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you been advised to undergo treatments or tests that you have not yet done, or, at the moment, are awaiting results, or have you experienced symptoms for which you have not sought medical attention?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Additional questions for Critical Illness insurance	Have you suffered from, been treated for, been diagnosed, consulted a health professional, received abnormal test results or had symptoms related to any of the following: tumor, polyp or any other growth, neurological or motor neuron disorders, multiple sclerosis, numbness, weakness or loss of sensation of extremities, ophthalmoneuritis, breast disorders (mass, cyst, unusual discharge, physical change, biopsy, abnormal mammogram or ultrasound), prostate disorders, liver disease, kidney disease, chronic bronchitis, emphysema, Crohn's disease, ulcerative colitis, vision or hearing problems (excluding myopia, presbyopia and otitis)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have two or more members of your immediate family (father, mother, brothers, sisters) suffered from cancer, heart disease, stroke, transient cerebral ischemia, multiple sclerosis, Huntington's chorea, colon polyps, kidney disorders, motor neuron disease, muscular dystrophy, Parkinson's disease, Alzheimer's disease or any other hereditary disease before the age of 60?	<input type="checkbox"/> Yes <input type="checkbox"/> No

If the Insured answers "NO" to the questions above, you are eligible for this offer.
Otherwise, please fill out the Life, Health and Disability paper or electronic Insurance Application.



Statements and Authorizations

The policyowner(s) and the Insured, where applicable:

- declare that all answers provided in this application are, to the best of their knowledge, true and complete.
- authorize Desjardins Financial Security Life Assurance Company (DFS) to issue a new policy.
- expressly authorize their beneficiary(es), heir(s) or estate liquidator(s) to provide DFS or its reinsurers with all the information or authorizations deemed necessary to study the claim and obtain the required proofs, in the event of death. A photocopy of this authorization is as valid as the original.
- can take advantage of the simplified offer only once for the same insured.
- acknowledge that the product and benefits were clearly explained.
- agree that the insurance be issued on the proposed insured and that the necessary information (names and contact information, dates of birth, sex, identification information and employer information, or financial situation for companies) indicated in policy 123456 be used to issue this policy.
- received information on accumulation products and were informed that investment income on any index account can be either positive or negative and is not guaranteed, if the product applied for is a universal life product.
- acknowledge that any misrepresentation, including the misrepresentation of smoking habits, may void the policy.
- have read this section before signing it.

Note: If the policyowner is a company, the person signing must specify that he is signing on behalf of the company and indicate his title. A completed application (08295E) must be attached to the application, along with the legal documents identified on the application.

Signatures

If the policyowner is a company, specify the name and title of the person who has the authority to sign on its behalf.

Signed at _____
 City or town, province _____ Date (YYYY – MM – DD) _____

X _____ X _____
 Policyowner: John Taylor Insured: John Taylor

Payment of Premiums

The policyowner(s) authorize(s) DFS to use the same frequency and method of premium payment for the new policy as those currently used for policy 123456. If the selected payment method for policy 123456 is “automatic withdrawal (PAD),” the holder(s) of the account on which the premiums for this new policy are debited, authorize(s) DFS to make pre-authorized debits (PADs) on the same account to pay the premiums for the new policy in accordance with the existing PAD agreement. The account holder(s) agree(s) to waive any written notice prior to the first debit scheduled after the new policy is in effect or any notice confirming debit changes. To change or set up a new pre-authorized debit agreement (PAD), please complete and send in the “Pre-Authorized Debit Agreement (PAD) Payor’s Authorization” form – 09312E.

Signatures

X _____
 Policyowner: John Taylor

First and last name of account holder	_____	First and last name of second account holder	_____
Signature	X _____	Signature (Only if two signatures are required)	X _____
Date	YYYY MM DD	Date	YYYY MM DD

If payment is made by cheque, the cheque amount included is \$ _____

Representative Information

The representative(s) declare(s) that they have provided to the policyowner(s) an illustration and disclosed in writing any conflict of interest related to this application.

Signature	X _____ John Advisor	Share	%	Representative code	7899
				Field office code	9987
First and last name of representative:		Share	%	Representative code	
				Field office code	