

REQUEST FOR CONVERSION

SECTION A STATEMENT OF POLICYHOLDER OR EMPLOYER

Name of policyholder or employer		Group number	Certificate or identification number	
Last name of member	First name	Date of:	YYYY	MM DD
		<input type="checkbox"/> Coverage termination		
		<input type="checkbox"/> Coverage reduction		
1. Will the member be submitting a disability claim? <input type="checkbox"/> Yes <input type="checkbox"/> No		2. Is the member recovering from a disability? <input type="checkbox"/> Yes <input type="checkbox"/> No		

ONLY COMPLETE THE FOLLOWING TABLE IF THE CONTRACT IS SELF-ADMINISTERED:

GROUP INSURANCE AMOUNTS ELIGIBLE FOR CONVERSION UNDER THE CONTRACT

	Life insurance			Critical illness insurance		
	Basic	Optional	Total	Basic	Optional	Total
Member						
Spouse						
Dependent children				Not available	Not available	Not available

Signature of policyholder or employer:

Date:

SECTION B STATEMENT OF MEMBER – Please read the information on the back of this form before completing this section.

Last name	First name	Date of birth	YYYY	MM	DD	Sex	<input type="checkbox"/> M <input type="checkbox"/> F
Address – No., street, apt.		City	Province	Postal code			
Telephone number	Cell number	E-mail*					

*Please provide this information only if you authorize a Desjardins Financial Security, hereinafter Desjardins Insurance, Independent Network representative or an SFL Partner of Desjardins Insurance representative to contact you by email.

Will you be employed again within 31 days of when your coverage ends? Yes No

If so, will you have group life insurance through your new employer?
 Yes – Specify amount: \$ No

TOTAL INSURANCE AMOUNTS REQUESTED UNDER THE CONVERSION PRIVILEGE

	Life insurance			Critical illness insurance		
	Basic	Optional	Total	Basic	Optional	Total
Member						
Spouse						
Dependent children				Not available	Not available	Not available

Spouse – Last name	First name	Date of birth	YYYY	MM	DD	Sex	<input type="checkbox"/> M <input type="checkbox"/> F
Child – Last name	First name	Date of birth	YYYY	MM	DD	Sex	<input type="checkbox"/> M <input type="checkbox"/> F
Child – Last name	First name	Date of birth	YYYY	MM	DD	Sex	<input type="checkbox"/> M <input type="checkbox"/> F

DECLARATION AND AUTHORIZATION FOR THE COLLECTION AND COMMUNICATION OF PERSONAL INFORMATION

I certify that all the information provided in this conversion request is complete and true. I acknowledge that all the benefits offered in the contract are subject to the provisions for limitations or reductions as well as to the exclusions stipulated therein. I acknowledge that I have read the information on the back of this form and that I have kept a copy thereof. I give my consent for the information provided herein to be given to a Desjardins Financial Security, hereinafter Desjardins Insurance, Independent Network representative or an SFL Partner of Desjardins Insurance representative so that they may contact me about products that I can convert my coverage into. A photocopy of this authorization is as valid as the original.

Signature of member:

Date:

SECTION FOR ADMINISTRATIVE USE ONLY

Date form received:	YYYY	MM	DD	Conversion deadline:	YYYY	MM	DD
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MAXIMUM INSURANCE AMOUNTS ELIGIBLE FOR CONVERSION BASED ON THE INSURED AMOUNTS, THE CONTRACT OR THE PROVINCE OF RESIDENCE

	Life insurance			Critical illness insurance <input type="checkbox"/> Claims checked		
	Basic	Optional	Total	Basic	Optional	Total
Member						
Spouse						
Dependent children				Not available	Not available	Not available

INFORMATION ABOUT THE ADVISOR ASSIGNED TO THE GROUP INSURANCE PLAN – If applicable.

Last name	First name	Address – No., street, apt.	City	Province	Postal code
Form checked by:		Date:			

IMPORTANT INFORMATION

- **Please print.**
- **Use a second 14141E form if you are requesting the conversion of insurance amounts for more than two children.**

Depending on your policy or province of residence, your group life and critical illness insurance benefits may include a conversion privilege allowing you to convert them into individual coverage. Please note that if you have already been paid the full critical illness insurance benefit, you will not be able to convert your group critical illness insurance into individual coverage.

The minimum and maximum insurance amounts that can be converted are stipulated in the policy or defined based on the laws of your province of residence. Some restrictions may apply in the event of a transfer to another group insurance plan.

Your group life and critical illness insurance benefits will remain in force 31 days after your coverage ends or is reduced, and are subject to certain restrictions. Your individual insurance policies will not come into force until the end of the 31-day period.

The conversion request must be received by Desjardins Insurance's head office within 31 days of the coverage termination or reduction date indicated in section A.

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 your personal information in a confidential manner. Access to your file is limited to authorized personnel who need it to access it to perform their duties. 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.

Please send us the form using one of the options below:

Online
desjardinslifeinsurance.com/send

By mail
Desjardins Insurance
C. P. 3000, Lévis (Québec) G6V 9X8

By fax
418-833-7051
or
1-866-833-7051

Keep a copy for your records.