

**AUTHORIZATION TO DISCLOSE
SUPPLEMENTARY PERSONAL INFORMATION
TO MY REPRESENTATIVE***

Lock-in number	Application number(s)
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This authorization form is not required for an insurance application.

* For the purposes of this form, the term “my representative” refers to the policyowner’s representative.

Proposed insured	
First and last names	Date of birth (YYYY/MM/DD)
Representative	
First and last names	Representative’s code

Nature and scope of authorization
By signing this authorization form, I authorize Desjardins Financial Security Life Assurance Company (DFS) to provide my representative and their financial centre administrative staff with supplementary personal information about me that is outside the scope of what is normally provided as part of an insurance application. I understand that my representative can use this information to recommend an insurance product that may be better suited to my situation or to help explain the underwriting decisions that are made. I understand that supplementary personal information may include details about: a) results from medical exams or lab tests; b) my health, including specific illnesses or health problems (e.g., mental illnesses, infectious diseases, use of prescription drugs, illicit drugs or alcohol), treatments I’ve received, or rehabilitation programs I’ve participated in; c) my health uncovered in the insurance application process, even if this information was unknown to me at the time I submitted my insurance application; d) my work history or financial situation; e) violations of the Highway Safety Code or other similar laws; f) Criminal Code offences, etc.

Authorization of proposed insured
By signing this authorization form, I understand and acknowledge the following: a) I have read and understood the nature and scope of this authorization. b) I authorize DFS to disclose supplementary personal information about myself to my representative and their financial centre administrative staff. c) DFS reserves the right not to disclose highly confidential personal details to my representative or their financial centre administrative staff. d) I can revoke this authorization at any time by calling DFS at 416-926-2991 or 1-866-926-2991. e) This authorization will remain valid for 60 days after the latest of the following dates: • the date on which DFS issues a new insurance contract or amends an existing contract; • the date on which DFS offers to issue a new insurance contract or amend an existing contract; • the date on which DFS sends me notice that my insurance application has been cancelled, declined or deferred.

Signatures

X _____
Signed at (city, province)

X _____
Date (YYYY/MM/DD)

X _____
Signature of proposed insured

X _____
Signature of guardian for children **under age 18** (Quebec) or legal representative for children **under age 16** (provinces other than Quebec)

X _____
First and last names of guardian or legal representative (PRINT IN UPPERCASE)

A photocopy of this authorization form is as valid as the original. Please return the completed form to DFS by fax at **416-324-7937**.