Desjardins
Insurance
Life • Health • Retirement

C. P. 3000
Lévis (Québec) G6V 9X8
desjardinslifeinsurance.com

REQUEST TO EXTEND BENEFITS AFTER A TERMINATION OF EMPLOYMENT

IMPORTANT

This form is only to be filled out to request an extension of benefits after the legal notice period has expired. The legal notice period and the obligation of the employer to maintain benefits during this period vary from province to province based on the number of years of service the member had accrued at the time of the termination of employment. Please refer to the applicable legislation in your province. Subject to approval by Desjardins Financial Security Life Assurance Company, hereinafter Desjardins Insurance, all of member's current benefits will be extended, with the exception of short-term and long-term disability insurance. The policyholder must inform the member that:

1) the contract must remain in force for the insurance to be continued and applicable premiums must be paid to the insurer;
2) no waiver of premium benefits applies to the continued benefits;
3) insurance will terminate if the member becomes insured as an employee under another group insurance plan.

IDENTIFICATION OF POLICYHOLDER – Please print.

Name of policyholder	Group No.

MEMBERS WHOSE EMPLOYMENT HAS TERMINATED

Last name	Certificate No.	Employment termination date (including the legal notice period) YYYY MM DD	Extension end date YYYY MM DD
First name	Is this employee currently disabled? ☐ Yes ☐ No		
Last name	Certificate No.	Employment termination date (including the legal notice period) YYYY MM DD	Extension end date YYYY MM DD
First name	Is this employee currently disabled? ☐ Yes ☐ No		
Last name	Certificate No.	Employment termination date (including the legal notice period) YYYY MM DD	Extension end date YYYY MM DD
First name	Is this employee currently disabled? ☐ Yes ☐ No		
Last name	Certificate No.	Employment termination date (including the legal notice period) YYYY MM DD	Extension end date YYYY MM DD
First name	Is this employee currently disabled? ☐ Yes ☐ No		
Last name	Certificate No.	Employment termination date (including the legal notice period) YYYY MM DD	Extension end date YYYY MM DD
First name	Is this employee currently disabled? ☐ Yes ☐ No		
Last name	Certificate No.	Employment termination date (including the legal notice period) YYYY MM DD	Extension end date YYYY MM DD
First name	Is this employee currently disabled? ☐ Yes ☐ No		
Last name	Certificate No.	Employment termination date (including the legal notice period) YYYY MM DD	Extension end date YYYY MM DD
First name	Is this employee currently disabled? ☐ Yes ☐ No		
Last name	Certificate No.	Employment termination date (including the legal notice period) YYYY MM DD	Extension end date YYYY MM DD
First name	Is this employee currently disabled? ☐ Yes ☐ No		

DECLARATION

I certify that all the information provided herein is complete and true.

Signature of authorized person: **Date :**

COMMENTS

Desjardins Insurance refers to Desjardins Financial Security Life Assurance Company.