HOW TO PROCEDE FOR THE ADHESION

1- Choose a plan
2- Complete « Chosen Plan » form
3- Complete the Application form Standard Life
4- Complete and sign withdrawal form
5- Return by mail to C.A.T.A.Q. Assurances Inc., 1954 Bergeron St., PO BOX 2117, Jonquiere, Quebec, Canada,G7X 7X6

CHOSEN PLAN

All the benefits programs are without any evidence of insurability at the beginning date of the insurance program for all employees effectively at work.

If you do not apply now and wish to do so later on, you will need to fill in a health statement.

If you wish to apply now please fill in this sheet and enclose two (2) cheques. The first one to the amount of the option chosen and made to the order of C.A.T.A.Q. ASSURANCES INC . The second one marked VOID will be used for monthly withdrawal.

OPTION CHOSEN: _____

NAME: _____ SURNAME : _____

ADRESS: _____

_____

_____

PHONE: ( ) _____-_____ CELL: ( ) _____-_____

EMAIL: _____

STANDARD LIFE

Group Life & Health

Application

Plan administrator statement

I Administrative information *(please print)*

Policyholder name			Policy no.	Division no.
Participant surname	Given name(s)	Initial	Certificate no.	
Date of permanent full-time employment *(with present employer)* *(YYYY/MM/DD)* / /	Eligibility date of insurance *(YYYY/MM/DD)* / /			
Occupation	Class	Salary	Salary basis: ❑ Annual ❑ Bi-weekly ❑ Hourly ❑ Monthly ❑ Weekly	_____ Hours worked per week

Health Spending Account

Variable allocations Combined: $ or Health: $ Dental: $

Participant statement

II Administrative information *(please print)*

Language: ❑ English ❑ French	Gender: ❑ M ❑ F	Date of birth *(YYYY/MM/DD)* / /	Marital status: ❑ Single ❑ Separated ❑ Divorced ❑ Common-law ❑ Married ❑ Widowed ❑ Civil union	If common-law, date on which cohabitation period started *(YYYY/MM/DD)* / /
Indian status ❑ Yes ❑ No	Main residence address *(no., street)*			Apt.
City	Province of residence	Workplace Province *(if different than province of residence)*		Postal code
Telephone no. *(day)* ( )	Telephone no. *(evening)* ( )			

Direct deposit

Type of bank account: ❑ Chequing ❑ Savings *Please complete this section or attach a personalized void cheque to ensure that we obtain your accurate banking information.*	Branch no.	Institution no.	Account no.
Financial institution name	Financial institution address		
Account holder signature *(if other than participant)*	Date *(YYYY/MM/DD)* / /		

III Information on your dependent(s)

	Surname	Given name(s)	Gender	Date of birth	Are your spouse and/or your children covered by another group insurance plan?[1]				Full-time student[2]	Total and permanent disability[3]	Dependent children of	
					Health care		Dental care					
			M F	*(YYYY/MM/DD)*	Yes	No	Yes	No			Spouse	Participant
Spouse			❑ ❑	/ /	❑	❑	❑	❑			✓	✓
Child			❑ ❑	/ /	❑	❑	❑	❑	❑	❑		
Child			❑ ❑	/ /	❑	❑	❑	❑	❑	❑		
Child			❑ ❑	/ /	❑	❑	❑	❑	❑	❑		
Child			❑ ❑	/ /	❑	❑	❑	❑	❑	❑		

[1] *If your spouse and/or children are covered under another group insurance policy, please complete section IV.*
[2] *If you have dependent children who have reached the first age limit stipulated in the contract, please complete section VII.*
[3] *If you have disabled dependent children who have reached the first age limit stipulated in the contract, please complete the Application for total and permanent disability status for a dependent child form PC GE10352 and attach it to this Application. This form can be obtained by calling us at 1-800-499-4415.*

IV Information about your spouse's group insurance plan

Name of your spouse's group insurer	Policy no.	Coverage:	Health care: ❑ Individual ❑ Family Dental care: ❑ Individual ❑ Family

V Choice of coverage

❑ Individual coverage *(only the participant is covered)* ❑ Family coverage *(the participant and his/her eligible dependents are covered)*

VI Exemption request for benefits already covered under your spouse's group insurance plan

I decline health insurance benefits:	I decline dental care benefits:
❑ For myself and my dependents ❑ For my dependents only	❑ For myself and my dependents ❑ For my dependents only

VII Confirmation of school attendance *(dependent children who have reached the first age limit)*

Given name(s)	Name of educational institution attended on a full-time basis	Attendance period		Telephone no. of institution
		Start *(YYYY/MM/DD)*	End *(YYYY/MM/DD)*	
		/ /	/ /	( )
		/ /	/ /	( )
		/ /	/ /	( )

The Standard Life Assurance Company of Canada reserves the right to confirm student status with the educational institution.

VIII Beneficiary designation

Beneficiary surname	Given name(s)	Relationship to participant	%

If the designated beneficiary is legal heirs or estate, please write in full "Legal heirs" or "Estate" and do not provide name(s), given name(s) or relationship to participant. If more than one beneficiary is designated and if one of the beneficiaries predeceases the participant, his/her share will be divided equally among the other designated beneficiaries.

IX Contingent beneficiary designation

If all of my beneficiaries predecease me, I designate the following individual(s) as my beneficiary(ies).

Beneficiary surname	Given name(s)	Relationship to participant	%

X Québec participants only *(to be completed if beneficiary is your spouse – marriage or civil union)*

In Québec, the designation of a spouse, excluding common-law spouse, as beneficiary is irrevocable unless otherwise specified. If you designate your spouse as beneficiary, Standard Life recommends that you make a revocable designation in order to facilitate any future request for a change of beneficiary. An irrevocable designation cannot be changed unless the beneficiary aged 18 or over signs a waiver of rights.

Please sign in the box corresponding to your choice ONLY IF you designate your SPOUSE as beneficiary.

The beneficiary designation is **revocable**	Or	The beneficiary designation is **irrevocable**
Participant signature		Participant signature

XI Declaration appointing trustee *(to be completed if beneficiary is under legal age)*

I hereby appoint _____ as Trustee to receive any amount due to any beneficiary under legal age and I declare that the receipt from such Trustee shall be a valid discharge to Standard Life of the amount so paid. I also hereby authorize such Trustee at his/her discretion to apply on behalf of such beneficiary the whole or any portion of such amount and the income derived therefrom for the care, maintenance, education, advancement in life or other benefit of such beneficiary.

Participant signature	Date *(YYYY/MM/DD)*
	/ /

XII Optional benefits

Please verify with your plan administrator if optional benefits are offered under your plan. If so and if you wish to apply for these benefits, please complete Optional benefits form GE8002 and indicate whether coverage is for:

❑ Yourself ❑ Your spouse ❑ Your dependent children

Please note that optional life benefits are subject to evidence of insurability and come into effect only when approved.

XIII Authorization

I hereby accept the conditions of this policy and I authorize the necessary contributions to be made through salary deductions, if applicable.

I consent to the use of my social insurance number as my certificate number under the group plan and as my identification number in the Standard Life database, and that it is my responsibility to advise my plan administrator if I do not wish my social insurance number to be used to identify me under the group plan.

I authorize my employer, the policyholder, the plan administrator, The Standard Life Assurance Company of Canada or their reinsurers, their respective agents to give, receive and share any personal information regarding my eligibility and my insurability or those of my dependents, if any under this plan.

I also authorize my employer to give my banking information to the Standard Life Assurance Company of Canada for the direct deposit of claim payments in my account. In addition, I agree to inform my employer as well as Standard Life of any change to my banking information, which could have an impact on the payment of my claims.

In the case of death, I expressly authorize my employer, the policyholder, the beneficiary, heir or liquidator of my estate to provide The Standard Life Assurance Company of Canada, when required by the latter, with all the information and authorizations permitting the assessment of the claim and the collection of evidence.

This consent is valid for the purpose of this contract, or any modification, extension or reinstatement thereof.

A photocopy of this consent is valid as the original if it is used for information-sharing purposes.

Participant signature	Date *(YYYY/MM/DD)*
	/ /

Desjardins

Individual Member
Corporate Member

DIRECT WITHDRAWAL APPLICATION

Account holder(s)

Surname and first name(s) of holder(s)	Telephone No.
Address (street, city, province)	
	Postal code

Financial institution

Name of financial institution		
	Institution No.	Transit No.
Address (street, city, province)		
		Postal code

Payee

Name of organization	
	Telephone No.
Address (street, city, province)	
	Postal code

Withdrawal authorization

I, the undersigned (if a legal person, hereto represented by its duly authorized representative[s]), authorize the Payee to effect withdrawals in my

account No. _____ , held at the financial institution, at the following frequency:

weekly every two weeks twice monthly

monthly other _____

Every withdrawal shall correspond to:

a fixed amount of $, which can be increased without any further authorization on my part, provided the Payee notifies me in writing at least ten days before the due date of the payment as modified;

a variable amount, of which I must be advised by the Payee in writing at least ten days before the due date.

For Direct Withdrawals - Corporate Members only:

I hereby waive my right to receive the above-mentioned ten-day advance notice.

for the following service: _____

I retain my right to revoke at any time this authorization by notifying in writing the Payee. I indemnify and save harmless the financial institution should this revocation fail to be honoured, except through gross negligence on its part.

I shall advise the Payee in writing and reasonably in advance of any change to these presents.

I acknowledge that the financial institution at which I maintain the account is not required to verify that the payment is drawn in accordance with this authorization. I certify that every person whose signature is required for the operation of the above-noted account has signed this authorization.

I acknowledge that the delivery of this authorization to the Payee constitutes delivery by me to the above-noted financial institution.

Reimbursement

The financial institution shall reimburse me, on behalf of the Payee, any amount withdrawn by mistake within 90 days of the withdrawal for an individual holder and within 10 days of the withdrawal for a corporate holder, provided that the reimbursement is claimed for one of the following reasons:

(a) the withdrawal was not made in accordance with my authorization;
(b) my authorization was revoked;

(c) I did not receive the ten-day advance notice prior to the date of withdrawal.

I understand that a written declaration to this effect must be given to my financial institution on the form it will provide for that purpose. Finally, I acknowledge that a claim for reimbursement filed after the above-mentioned time limits must be settled between me and the Payee, without any liability or commitment on the part of my financial insitution.

Consent to disclosure of information

I hereby consent to the disclosure of the information contained in my Direct Withdrawal Application to the financial institution, provided such information disclosure is directly related to and required for the smooth application of the rules governing pre-authorized debits.

Signature of account holder(s)

_____ _____
Signature of account holder Date

_____ _____
Signature of second holder Date
(for a joint account requiring two signatures)

IMPORTANT NOTICE: Attach a personal blank cheque marked "VOID" in order to avoid any transcription error. If you change accounts or financial institutions, please notify the Payee.