Desjardins Insurance
Life • Health • Retirement

C. P. 3000
Lévis (Québec) G6V 9X8
desjardinslifeinsurance.com/planmember
Tel.: 1-800-263-1810

Group insurance - Contract administration

DEPENDENT'S STATEMENT

FILL OUT THIS STATEMENT ONLY IF:
- your insurance certificate specifies family, couple or single-parent coverage;
- you are changing your individual coverage to family, couple or single-parent coverage;
- you are adding a new eligible dependent.

Proof of registration in an educational institution is required to pay benefits for dependent children aged 18 or older, if all the required information is not provided. Refer to your policy for eligible age.

A IDENTIFICATION – Please print.

Name of policyholder	Group number	Division number
MARVELL SEMICONDUCTOR CANADA, INC.	M00149	

Last name of member	First name	Certificate or identification number

B IDENTIFICATION OF ELIGIBLE DEPENDENTS – According to the contract.

SPOUSE

Last name	First name	Date of birth (YYYY MM DD)	Sex
			☐ M ☐ F

☐ Spouse
☐ Common-law - Start date of cohabitation: YYYY MM DD

- Was a child born of this union? ☐ No ☐ Yes - Provide details below.

Other insurance	Covered care or benefit	Coverage	If your spouse is also insured by Desjardins Insurance*
☐ No ☐ Yes - specify to the right	☐ Medical care[1] ☐ Paramedical care[1] ☐ Dental care	☐ Individual ☐ Family ☐ Single-parent ☐ Couple	Group no.: Certificate no.:

DEPENDENT CHILDREN

1

Last name	First name	Date of birth (YYYY MM DD)	Sex
			☐ M ☐ F

Other insurance: ☐ Same as spouse (above) ☐ No ☐ Other

☐ Child with functional impairment[2] YYYY MM DD YYYY MM DD
☐ Child aged 18 or older[3] and full-time student - please specify: Period: From To

Name of educational institution:

2

Last name	First name	Date of birth (YYYY MM DD)	Sex
			☐ M ☐ F

Other insurance: ☐ Same as spouse (above) ☐ No ☐ Other

☐ Child with functional impairment[2] YYYY MM DD YYYY MM DD
☐ Child aged 18 or older[3] and full-time student - please specify: Period: From To

Name of educational institution:

3

Last name	First name	Date of birth (YYYY MM DD)	Sex
			☐ M ☐ F

Other insurance: ☐ Same as spouse (above) ☐ No ☐ Other

☐ Child with functional impairment[2] YYYY MM DD YYYY MM DD
☐ Child aged 18 or older[3] and full-time student - please specify: Period: From To

Name of educational institution:

- **Note 1: Care included in Extended health care benefit.**
- **Note 2: Please complete Confirmation of a dependent child's functional impairment form no. 09296E and return it to the address shown on the form.**
- **Note 3: Refer to your policy for eligible age.**

* Desjardins Insurance refers to Desjardins Financial Security Life Assurance Company (DFS).

C DECLARATION

I declare that the information above is complete and accurate. I can provide, upon request, proof of eligibility of my dependents (e.g. proof of marriage, cohabitation, birth, adoption, registration in an educational institution).

Signature of member: **Date:**

PLEASE SEND THE ORIGINAL TO DESJARDINS INSURANCE AND KEEP A COPY FOR YOUR FILE.

Desjardins Insurance refers to Desjardins Financial Security Life Assurance Company.

PRINT NEW REQUEST