



DIRECT DEPOSIT AUTHORIZATION

Last name of the beneficiary of the benefit		First name	Identification number	
No., street, apartment			Date of birth (YY-MM-DD)	
			Contract number	
Province	Postal code		Telephone number Area code + number	

I hereby authorize Desjardins Financial Security Life Assurance Company to deposit my monthly benefit payment, through the **DIRECT DEPOSIT** system, into my account at the financial institution indicated below:

NAME _____
AND _____
ADDRESS _____
OF FINANCIAL _____
INSTITUTION _____

_____ Identification number (transit) _____

Account number _____
(Please include a specimen cheque marked "VOID")

Any credit entered in my account in accordance with this authorization will be identified with a **DIRECT DEPOSIT** transaction code and I acknowledge that the credit in question shall constitute an amount paid in accordance with this authorization.

This authorization will become effective as of _____
The authorization will terminate following a 10-day advance written notice which Desjardins Financial Security Life Assurance Company will transmit to me or I to it.

Signature _____ Date _____

Desjardins Insurance refers to Desjardins Financial Security Life Assurance Company.

RETURN TO: Life Claims
Desjardins Financial Security Life Assurance Company
200, rue des Commandeurs
Lévis (Québec)
G6V 6R2