Desjardins
Insurance
LIFE • HEALTH • RETIREMENT

GROUP INSURANCE - DISABILITY CLAIMS

DIRECT DEPOSIT ENROLLMENT
DISABILITY CLAIMS
FOR THE MEMBER

Last name and first name of the member	Identification or certificate no.
Address - no., street, apartment	Policy or group or contract no.
City	Telephone no. ( ) -
Province / Postal code	

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

NAME AND ADDRESS OF FINANCIAL INSTITUTION _____

Institution number: _____

Transit/Branch number: _____

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 be effective on _____.

The authorization will terminate following a 10-day written notice by either Desjardins Financial Security Life Assurance Company or me.

Signature _____ **Date** _____

PRINT NEW REQUEST

RETURN TO: **Disability Claims**
Desjardins Financial Security Life Assurance Company
PO Box 4593, STN A
Toronto ON M5W 4X7