APPLICATION OR CHANGE FOR INSURANCE

Please specify : Application ☐ or Change ☐

P.O. Box 10500, Station Sainte-Foy, Quebec, QC G1V 4H6

PARTICIPANT TO COMPLETE

Identification of the Participant

Last Name	First Name	S.I.N.

General Information

Address		Work Tel.
Town/City	**Province**	**Home Tel.**

Postal Code	Email	Date of Birth (Y / M / D)	Language Preference	Gender
			◯ French ◯ English	◯ M ◯ F

Beneficiary

The amount insured will be payable to my estate ◯

OR

I wish to designate the following beneficiary(ies) in the event of my death:

Beneficiary Name(s): _____

Relationship to Participant ☐ Legal spouse ☐ Common-law spouse ☐ Legal spouse and son(s)/daughter(s) ☐ Common-law spouse and son(s)/daughter(s) ☐ Son(s)/daughter(s) ☐ Father/mother ☐ Brother(s)/sister(s) ☐ Other

Beneficiary status chosen*:

◯ Revocable (beneficiary designation may be changed at any time)

◯ Irrevocable (beneficiary designation can only be changed with the written consent of the designated beneficiary(ies)

* In Quebec, if no beneficiary status is specified, the designation of the legal spouse is irrevocable and the designation of any other person is revocable.

Signature of Participant

I HEREBY AUTHORIZE MY EMPLOYER TO DEDUCT FROM MY SALARY THE REQUIRED PREMIUMS FOR THE COVERAGE I HAVE CHOSEN. I HEREBY AUTHORIZE MY EMPLOYER AND THE INSURER TO USE THE ABOVE INFORMATION, INCLUDING MY SOCIAL INSURANCE NUMBER, FOR ADMINISTRATIVE PURPOSES. I HEREBY CERTIFY THAT ALL ABOVE INFORMATION IS TRUE AND COMPLETE. I CONFIRM THAT I HAVE READ THE NOTICE ON THE REVERSE REGARDING MY INSURANCE FILE AND PERSONAL INFORMATION AND HAVE KEPT A COPY OF THIS FORM.

Date: Y M D Signature: _____

PARTICIPANT TO COMPLETE

Coverage

You must select one of the following types of coverage (even if requesting an exemption)

	INDIVIDUAL	FAMILY	SINGLE-PARENT (1)
Health Insurance (and Dependents' Life Insurance if applicable)	◯	◯	◯
Exemption requested for Health Insurance ◯ (exemption does not apply to Dependents' Life Insurance)			
Dental Care Insurance (if applicable)	◯	◯	◯
Exemption requested for Dental Care Insurance ◯			

	PARTICIPANT	SPOUSE
Optional Accidental Death and Disemberment (if applicable)		
Amount of Optional Accidental Death and Disemberment requested	$ _____	$ _____ (3)

	PARTICIPANT	SPOUSE	CHILDREN
Optional Life Insurance (if applicable)			
Amount of Optional Life Insurance requested	$ _____	$ _____ (2) (3)	$ _____ (2) (3)

Identification of Spouse:

MAIDEN NAME (If applicable)	FIRST NAME	GENDER	DATE OF BIRTH (Y / M / D)
		◯ M ◯ F	

Non-smoker's declaration

By checking the non-smoker declaration box below, you (and your spouse, if applicable) are declaring that the following statement is true and complete. You also acknowledge that if you make a false declaration, your coverage may be voided.

"I understand that to be considered a non-smoker, I must not have smoked during the twelve (12) months prior to the application for insurance. I understand that the insurer may periodically require confirmation of non-smoker status; in such case I must be able to meet the requirements in force at that time and return confirmation within 30 days of the insurer's request, failing which I will no longer benefit from non-smoker status and the associated reduction in premiums, effective as of the date of the insurer's request."

PARTICIPANT: Non-smoker ◯ Smoker ◯ **SPOUSE:** Non-smoker ◯ Smoker ◯

NOTE (1) Single-Parent: This coverage may not be available under your group insurance plan. Please check with your plan administrator.
NOTE (2) Optional Life Insurance: Do not include the amount of Basic Life Insurance coverage.
NOTE (3) Optional Life Insurance: This coverage may not be available under your group insurance plan. Please check with your plan administrator.

PLAN ADMINISTRATOR TO COMPLETE

Plan Administrator

Name of group policyholder					Group No.
Employee No.	**Class No.**	**Annual salary**	**Date of employment (Y / M / D)**	**Date of eligibility (Y / M / D)**	**Date application submitted by employee to employer (Y / M / D)**
		$			

Is the participant eligible for a governmental workers' compensation program? ◯ Yes ◯ No

Employment Status

Permanent ◯

Temporary ◯ ▶ Full Time ◯ Part Time ◯ Occupation _____

I certify that all information above is true and complete.

Y M D
Date

Name (please print)

Tel. _____ Ext. _____

Signature of Plan Administrator

NOTICE

Personal information and insurance file

To maintain the confidentiality of your personal information, SSQ, Life Insurance Company Inc. will create an insurance and annuity file to hold information about your application for insurance or an annuity, along with information about any insurance claims you make.

Access to this file will be restricted to employees or agents who are responsible for underwriting, investigation and claims, and any other person you may authorize.

Your file will be kept in SSQ's offices in Sainte-Foy, Quebec.

You have the right to consult the personal information held in your file and, if necessary, have this information rectified, by submitting a request in writing to the following address: Personal Information Protection Officer, SSQ Insurance, P.O. Box 10500, Station Sainte-Foy, Quebec, QC G1V 4H6.