SSQ Financial Group

APPLICATION 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	**Date of Birth** Y M D	**Language Preference** ○ English ○ French	**Gender** ○ M ○ F

Beneficiary

OR **The amount insured will be payable to my estate** ○

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:

Coverage

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

Health Insurance (and Dependents' Life Insurance if applicable) — INDIVIDUAL ○ FAMILY ○ SINGLE-PARENT (1) ○

Exemption requested for Health Insurance ○ (exemption does not apply to Dependents' Life Insurance)

Dental Care Insurance (if applicable) — ○ ○ ○

Exemption requested for Dental Care Insurance ○

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

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

Identification of Spouse:

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

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 ○ **SPOUSE:** Non-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.

PARTICIPANT 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.

V ADMINISTRATOR TO COMPLETE