SSQ Financial Group

APPLICATION FOR INSURANCE

PARTICIPANT TO COMPLETE

Identification of the Participant

Last Name	First Name	S.I.N.
Address		Work Tel.
Town/City	Province / Postal Code	Home Tel.
Date of Birth (Y M D)	Language Preference ◯ English ◯ French / Gender ◯ M ◯ F	Do you have a spouse (married, common-law or civil union spouse)? ◯ Yes ◯ No

Coverage

Health Insurance ◯ Individual ◯ Family ◯ None. I am covered under my spouse's plan.

Dental Care Insurance ◯ Individual ◯ Family ◯ None. I am covered under my spouse's plan.

Optional Life Insurance (if applicable)

	PARTICIPANT	SPOUSE
Amount of Optional Life Insurance requested (1) (2)	$ ______	$ ______

Identification of Spouse:

Last Name | 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 ◯ ______ Signature of Participant

SPOUSE: Non-smoker ◯ ______ Signature of Spouse

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

Spouse and Dependent Children

Spouse's last name: ______ First name: ______ Date of birth: Y M D Gender: ◯ M ◯ F

What type of Health Insurance coverage does your spouse have under another policy? ◯ Individual ◯ Family ◯ None

What type of Dental Care Insurance coverage does your spouse have under another policy? ◯ Individual ◯ Family ◯ None

First and last name of child	Gender	Date of birth	Does the child have a disability?	Is the child a full-time student?	Name of educational institution
	◯ M ◯ F	Y M D	◯ Yes ◯ No	◯ Yes ◯ No	
	◯ M ◯ F	Y M D	◯ Yes ◯ No	◯ Yes ◯ No	
	◯ M ◯ F	Y M D	◯ Yes ◯ No	◯ Yes ◯ No	
	◯ M ◯ F	Y M D	◯ Yes ◯ No	◯ Yes ◯ No	
	◯ M ◯ F	Y M D	◯ Yes ◯ No	◯ Yes ◯ No	
	◯ M ◯ F	Y M D	◯ Yes ◯ No	◯ Yes ◯ No	

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:

Name(s): ______ **Relationship:** ______

This beneficiary designation is*:

◯ 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, when no beneficiary status is specified, designation of the legal spouse is irrevocable and designation of any other beneficiary is revocable.

If you designate more than one beneficiary, the insurance proceeds will be distributed evenly between them unless you specify the percentage of the insurance you wish to allocate to each beneficiary.

I hereby appoint (full name, relationship) ______ as Trustee to receive any amount payable to a minor beneficiary under this policy and declare the receipt by such Trustee shall discharge the Insurance Company for the amount so paid. And I do hereby authorize the Trustee, within his/her discretion, to expend all or any such amount and/or the income resulting from the proceeds for the maintenance or education of such minor. (You must appoint a trustee if your beneficiary is under age 18.)

Signature of Participant

I HEREBY AUTHORIZE MY EMPLOYER TO DEDUCT FROM MY SALARY THE PREMIUMS REQUIRED FOR THE COVERAGE I HAVE SELECTED. I AUTHORIZE MY EMPLOYER AND SSQ TO USE THE ABOVE INFORMATION, INCLUDING MY SOCIAL INSURANCE NUMBER, FOR ADMINISTRATIVE PURPOSES. I CERTIFY THAT ALL INFORMATION ON THIS FORM IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE. FURTHERMORE, I ACKNOWLEDGE THAT I HAVE READ THE PERSONAL INFORMATION PROTECTION NOTICE ON THE REVERSE AND HAVE KEPT A COPY OF THIS FORM.

Date: Y M D Signature: ______

PLAN ADMINISTRATOR TO COMPLETE

Plan Administrator

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

I certify that all information above is true and complete.

______ Date ______ Name (please print)

Tel. ______ Ext. ______ ______ Signature of Plan Administrator

PERSONAL INFORMATION PROTECTION

To safeguard the confidentiality of your personal information, SSQ, Life Insurance Company Inc. opens an insurance file to hold information about your application for insurance and any claims you make.

Access to your file is restricted to those employees and agents of SSQ who must consult your file for underwriting, claims adjudication and claims audit purposes, and any other person you may authorize.

Your file is kept at SSQ's offices. You may consult the personal information contained in your file, and have any errors or inaccuracies rectified, by making a request in writing to the following address:

Personal Information Protection Officer
SSQ, Life Insurance Company Inc.
5160 Yonge Street
Suite 730
Toronto ON M2N 6L9

SSQ, Life Insurance Company Inc. has a strict Personal Information Protection Policy. To obtain a brochure outlining this policy, you may send a request in writing to SSQ's Personal Information Protection Officer at the address provided above.