SSQ Financial Group

PARTICIPANT COMPLETES SECTIONS 1-2-6 AND SECTIONS 3 AND 4 IF NECESSARY
EMPLOYER COMPLETES SECTION 5
SECTION 7 FOR USE OF SSQ ONLY
PLEASE PRINT CLEARLY

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

1 IDENTIFICATION OF PARTICIPANT

Last Name	First Name	Social Insurance Number

2 GENERAL INFORMATION

Address

Postal Code

Telephone (work)	Telephone (home)	Date of birth Y Y Y Y M M D D	Gender M ☐ F ☐	Language Preference Fr. ☐ Eng. ☐

DESIGNATION OF SPOUSE

Last Name	First Name	Date of birth Y Y Y Y M M D D	Gender M ☐ F ☐

3 PLANS

	Application	Change (complete "Event" section if necessary)
	* Employer must complete Section 5 relating to exemption.	I want to change my coverage status or my plan as indicated below:
❶ **HEALTH INSURANCE PLAN** – COMPULSORY	IND / SINGLE-PARENT / FAM / EXEMPTION	IND / SINGLE-PARENT / FAM / EXEMPTION
HEALTH 1	☐ ☐ ☐ ☐*	☐ ☐ ☐ ☐*
HEALTH 2 (Minimum duration of participation: **12** months)	☐ ☐ ☐ ☐*	☐ ☐ ☐ ☐*
HEALTH 3 (Minimum duration of participation: **24** months) (You must choose only one of these plans) – **see note 1 over)**	☐ ☐ ☐ ☐*	☐ ☐ ☐ ☐*
❷ **ADDITIONAL PLAN 1** – OPTIONAL if group votes in favour (Dental Care Insurance) (Minimum duration of participation: **48** months – **see note 2 over)**	☐ ☐ ☐	☐ ☐ ☐ REMOVE (see note 2 over) ☐
❸ **ADDITIONAL PLAN 2** – COMPULSORY (Long Term Disability Insurance)		WAIVER (see note 3 over) ☐
❹ **ADDITIONAL PLAN 3 (see note 4 over)**		
A) PARTICIPANT'S LIFE INSURANCE - First $10,000 compulsory with right to opt out	☑ $10,000 **coverage automatic** upon registration ☐ I do not want the above $10,000 coverage	☐ **I wish to remove this coverage in accordance with my right to opt out of the minimum compulsory amount of $10,000**
Choice of total coverage amount (including first $10,000)	☐ $25,000 ☐ $50,000 ☐ $75,000 ☐ $100,000 ☐ $125,000 ☐ $150,000 ☐ $175,000 ☐ $200,000 ☐ $225,000 ☐ $250,000	**Choice of new total amount desired:** ☐ $10,000 ☐ $25,000 ☐ $50,000 ☐ $75,000 ☐ $100,000 ☐ $125,000 ☐ $150,000 ☐ $175,000 ☐ $200,000 ☐ $225,000 ☐ $250,000
B) DEPENDENT'S BASIC LIFE INSURANCE	☐ I wish to have this coverage	☐ I want to add this coverage ☐ I want to remove this coverage
C) SPOUSE'S OPTIONAL LIFE INSURANCE (Available only if you have B) DEPENDENT'S BASIC LIFE INSURANCE)	☐ $10,000 ☐ $20,000 ☐ $30,000 ☐ $40,000 ☐ $50,000 ☐ $60,000 ☐ $70,000 ☐ $80,000 ☐ $90,000 ☐ $100,000	**Choice of new total amount desired:** ☐ $10,000 ☐ $20,000 ☐ $30,000 ☐ $40,000 ☐ $50,000 ☐ $60,000 ☐ $70,000 ☐ $80,000 ☐ $90,000 ☐ $100,000 ☐ I want to remove this coverage

EVENT justifying the request for change. Indicate date of the event Y Y Y Y M M D D **(Complete designation of spouse, if applicable)**
(For cohabitation, indicate **start date**)

1. COHABITATION ☐ (common-law)
   → 1.1 Was a child born of this union? → If yes, child's date of birth Y Y Y Y M M D D
   → 1.2 Start date of cohabitation Y Y Y Y M M D D
2. MARRIAGE OR CIVIL UNION ☐
3. ADOPTION ☐
4. BIRTH ☐
5. CUSTODY OF A CHILD ☐
6. SEPARATION ☐
7. DIVORCE ☐
8. TERMINATION OF SPOUSE'S INSURANCE ☐
9. REGULAR EMPLOYMENT STATUS OBTAINED ☐

4 BENEFICIARY

Name of the beneficiary(ies):

I hereby designate as my beneficiary (in the event of my death): Spouse (married or civil union) (1) ☐ Common-law spouse (7) ☐ Sons-daughters (2) ☐
Spouse (married or civil union) and sons-daughters (6) ☐ Father-mother (3) ☐ Common-law spouse and sons-daughters (8) ☐ Brothers-sisters (4) ☐

Beneficiary is revocable ☐ (may be changed at any time)
Beneficiary is irrevocable ☐ (may be changed only with written consent of irrevocable beneficiary)
OR insurance proceeds payable to the Estate of the Participant ☐

Under Quebec law, when no beneficiary status is specified, designation of the **married or civil union** spouse is irrevocable and designation of any other beneficiary is revocable.

In this document, SSQ designates SSQ, Life Insurance Company Inc.

CSQ

APPLICATION FOR INSURANCE ☐

Complete all sections that apply (Section 1 must be completed) ◄ **REQUEST FOR CHANGE** ☐

5 Employer

Name of Organization	Establishment No.	Group No. J

Employee No.	Date of Employment Y Y Y Y M M D D	Date of Eligibility Y Y Y Y M M D D	Date Received from Employee Y Y Y Y M M D D	Date the contract was signed Y Y Y Y M M D D

Absence from work

Is the participant currently absent from work?
☐ No ☐ Yes If yes, reason

Start date of absence Y Y Y Y M M D D
The participant has:
☐ maintained coverage ☐ suspended coverage (except for the Health1 Plan)

Employment Status

Full time ☐
Part time ☐
▶ ______ % of full-time

Employment Category

Teacher ☐
Nurse ☐
Support ☐
Professional ☐
Support (Ch. 10, adult education) ☐
Other ☐

I certify that this information is complete and accurate.

Y Y Y Y M M D D
Date

Telephone No. - Ext.

Name of Employer's Representative (in block letters)

Signature of Employer's Representative

ANNUAL SALARY ACCORDING TO COLLECTIVE AGREEMENT
(as though 100% of full time)

$ ______ / year

Reserved for health sector

During the reference period, the participant has worked 25% or less of full-time and has decided:

☐ to participate in the life insurance and disability insurance plans under the collective agreement.
☐ not to participate in the life insurance and disability insurance plans under the collective agreement.

Exemption from the Health Insurance Plan

☐ Start of exemption → Keep proof of the insurance allowing the exemption.
☐ End of exemption End date of exemption Y Y Y Y M M D D → Provide proof of insurance termination allowing the exemption.

Reason:

Comments

6 Signature

I hereby authorize my employer to deduct the premiums applicable to the coverage I have selected from my salary. I authorize my employer and SSQ to use the information contained in this form, including my Social Insurance Number, for administrative purposes. I certify that all of the information I have provided in this form is true and complete to the best of my knowledge. Furthermore, I acknowledge having read the Personal Information and Insurance File notice provided on the back of this form and having kept a copy of this form.

Date: Y Y Y Y M M D D Participant's Signature

7 RESERVED FOR SSQ

N° groupe J	N° certificat	En vigueur A A A A M M J J	Classe	Adhérent sélection Non ☐ Oui ☐

	MAL.	FRAIS DENT.	I.H.	R.I.P.	VIE	M.M.A.	VIE P.À.C.	M.M.A. P.À.C.	VIE CONJOINT	M.M.A. CONJOINT	VIE ENFANTS	M.M.A. ENFANTS	RENTES SURV.		
BASE															
ADD.															

Adhérent() fumeur(se) Oui ☐ Non ☐
Conjoint(e) fumeur(se) Oui ☐ Non ☐
Codifié par ______ A A A A M M J J
Code certificat

White copy for SSQ — Yellow copy for employer — Pink copy for participant

FV3359A (2009-11)

COVERAGE CHOICE

Note 1
According to the Quebec Act respecting prescription drug insurance, subject to the exemption entitlement, participation in the health insurance plan is compulsory because it includes prescription drug coverage. For more information, please consult the "Participation in insurance" subsection in the general information section of the booklet.

Note 2
Participation in the Dental Care Insurance Plan is optional for any employee who is eligible for this dental coverage who belongs **to a group that has the plan** because at least 40% of members voted in favour of it. Therefore, only those participants who have chosen to participate in this plan will have dental coverage. The minimum duration of participation in this plan is 48 months. However, participants who wish to terminate their participation before the end of this 48-month period must provide proof to SSQ that they are covered under another group insurance plan with dental care coverage. Groups for which the rate of enrolment is under 40% will not have access to the Dental Care Insurance Plan.

Note 3
The participant must complete the "Waiver privilege for the Long Term Disability Insurance Plan" form (FV3783A) and meet the conditions mentioned on this form.

Note 4
Additional Plan 3 - Life Insurance stipulates that a minimum of $10,000 in Participant's Life Insurance is compulsory for all employees eligible for the current plan. However, participants have a maximum of 180 days, from the date that the $10,000 in Participant's Life Insurance is granted comes into force, to make a request to opt out under the provisions of the contract.

Coverage for amounts greater than $10,000 for Participant's Life Insurance and other life insurance plans is **optional**. Please note that coverage for amounts of $10,000, $25,000 and $50,000 is available without the requirement for evidence of insurability for the 180-day period following the date of eligibility. After this period, evidence of insurability is required.

Coverage for amounts greater than $50,000 for Participant's Life Insurance as well as any amounts for Spouse's Optional Life Insurance always require that evidence of insurability be presented to SSQ.

NOTICE OF NEW FILE

File and Personal Information

In order to maintain the confidentiality of information concerning the persons it ensures, SSQ, Life Insurance Company Inc. opens an insurance file to hold personal information about the application for insurance and any insurance claims made.

With the exception of certain cases provided for under applicable legislation, access to insured persons' files is restricted to those employees, legal agents and service providers who must consult these files for the purpose of contract management, inquiries or underwriting, in addition to any other person authorized by the insured person. SSQ keeps these insurance files in its offices.

All persons insured with SSQ have the right to consult the information contained in their file and, if necessary, to have any errors or inaccuracies corrected, free of charge, by making a written request to the attention of SSQ's Personal Information Protection Officer at the following address: SSQ, Life Insurance Company Inc., 2525 Laurier Boulevard, P.O. Box 10500, Station Sainte-Foy, Quebec QC G1V 4H6. However, SSQ may charge fees for transcribing, reproducing or sending this information. The person making the request for information will be informed beforehand of the approximate amount that will be charged.

SSQ may use a list of its insureds for the purpose of offering insurance and financial services. If you do not want your name to be included on this list, you must send a written request to SSQ's Personal Information Protection Officer at the address provided above.