SSQ Financial Group

PARTICIPANT COMPLETES SECTIONS 1-2-3-7 AND SECTIONS 4 AND 6 IF NECESSARY
EMPLOYER COMPLETES SECTION 5
SECTION 8 IS FOR USE OF SSQ ONLY

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

YZ Management personnel of the Quebec public and parapublic sectors

APPLICATION FORM ☐
Complete the sections that apply ◀ REQUEST FOR CHANGE ☐

PLEASE PRESS FIRMLY AND WRITE LEGIBLY

1 General information - Participant

1.1 Last Name	1.2 First Name	1.3 Social Insurance Number

1.4 Address	1.5 Telephone (at work)

1.6 Postal Code	1.7 Telephone (at home)	1.11 Date of Birth (Y M D)	1.12 Gender	1.13 Language Preference
			M ☐ F ☐	Fr. ☐ Eng. ☐

1.9.1 Are you working for 2 employers or more? No ☐ Yes ☐
1.9.2 If yes, names of the employers

1.10.1 Do you have another position or other duties with this employer? No ☐ Yes ☐
1.10.2 If yes, title or occupation:
1.10.3 Are you on unpaid leave? No ☐ Yes ☐

1.14.1 Are you already insured with SSQ? No ☐ Yes ☐ 1.14.2 If yes, your Certificate No.
1.14.3 Is this request the result of a transfer from one employer to another? No ☐ Yes ☐

1.15 Event justifying the request for change. Indicate the date of the event (For cohabitation, indicate the start date) (Y M D)

(Complete section 4, if necessary)

1. COHABITATION ☐ → 1.1 Was a child born of the union? → If yes, child's date of birth (Y M 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 ☐

2 Plans

• You must select a coverage status from the following:

	2A - Application	2C - Change	
		2.C.A. ADD ▼	2.C.R. REMOVE ▼
	IND (2.A.1) / SINGLE-PARENT (2.A.2) / FAM (2.A.3) / EXEMPTION* (2.A.4)	IND (2.C.A.1) / SINGLE-PARENT (2.C.A.2) / FAM (2.C.A.3) / EXEMPTION* (2.C.A.4)	IND (2.C.R.1) / SINGLE-PARENT (2.C.R.2) / FAM (2.C.R.3) / EXEMPTION* (2.C.R.4)
2.1 COMPULSORY ACCIDENT AND HEALTH INSURANCE PLAN	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐
2.2 COMPULSORY BASIC LIFE INSURANCE PLAN (including life insurance and accidental dismemberment insurance for the participant, the spouse and the dependents)	COMPULSORY		
2.3 COMPULSORY BASIC LONG-TERM DISABILITY INSURANCE PLAN	COMPULSORY		
2.4 COMPULSORY ADDITIONAL LONG-TERM DISABILITY INSURANCE PLAN (CAP)	COMPULSORY		
2.5 OPTIONAL ADDITIONAL LIFE INSURANCE PLAN (See note 1 on back)		INCREASE TO** ▼	DECREASE TO ▼
a) Participant's additional life insurance (the total amount of coverage can be 1, 2, 3, 4, or 5 times the annual salary)	2.A.5 _____ times (indicate total times requested)	2.C.A.5 _____ times (indicate total times requested)	2.C.R.5 _____ times (indicate total times requested)
b) Spouse's additional life insurance (amount may vary from 1 to 10 units of $10,000)	2.A.6 _____ units of $10,000 (indicate total number of units requested)	2.C.A.6 _____ units of $10,000 (indicate total number of units requested)	2.C.R.6 _____ units of $10,000 (indicate total number of units requested)

* The part of section 5 relating to exemption must be completed by the employer. ** Attach the "Declaration of health condition" form (FSEL108), if necessary.

3 Beneficiary

3.1 Insurance proceeds shall be payable to the Estate of the participant ☐

OR

3.2 Beneficiary is revocable* ☐ (may be changed at any time)
3.3 Beneficiary is irrevocable * ☐ (cannot be changed without beneficiary's written consent)

* 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.

3.4 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) ☐ Other (5) ☐

Name(s) of the Beneficiary(ies):

4 Designation of spouse

4.1 Last Name	4.2 First Name	4.3 Date of Birth (Y M D)	4.4 Gender (M F)

5 Employer

5.1 Payroll No.	5.2 CARRA employer No.	5.3 Received from the employee (Y M D)	5.4 Date of appointment (Y M D)	5.5 SSQ Group No.

5.6 Ministry	5.7 Employment category (PS)	5.8 Occupation code (HSS)	5.9 Classification (Ed., org.)	5.10 Name of employer, organization or establishment
	—			

5. 11 Employment status (See note 2 on back)

5.11.1 Permanent ☐
5.11.2 Temporary / Eligible ☐
5.11.3 Casual ☐
5.11.4 Full-time ☐
5.11.5 Part-time ☐ 5.11. 6 _____ %

5.11.7 If **Temporary** / Eligible, duration of employment: From (Y M D) to (Y M D)

5.12.1 Title or occupation of the participant:
5.12.2 Basic annual salary: $
5.12.3 Date of beginning of the participant's absence (Y M D)
5.12.4 Salary category
5.12.5 Salary scale (organization) Min. Max. Max. on merit

5.13 Position already validated ▶ ☐ No 5.13.1 If no = new position (See note 4 on back)
☐ Yes 5.13.2 If yes, name of person being replaced: 5.13.3 SIN
5.13.4 Departure date: (Y M D) 5.13.5 Reason for departure:

5.14 I certify that the information is complete and accurate.
5.14.1 Identification of the individual who completed the form: First and Last Name in block letters
5.14.2 Date: (Y M D)
5.14.3 Telephone: ( ) - Extension:
5.14.4 Name of the employer's representative
5.14.5 Date: (Y M D)
5.14.6 Signature of the employer's representative **(see note 3 on back)**

5.15 Exemption

☐ 5.15.1 Start of exemption ▶ 5.15.2 Start date of exemption (Y M D)
☐ 5.15.3 End of exemption ▶ 5.15.4 End date of exemption (Y M D)

▶ Keep proof of the insurance allowing exemption in the manager's file.
▶ Keep proof of the termination of the insurance allowing exemption in the manager's file.

5.16 Comments

6 Non-smoker's statement

"I, the undersigned, declare that I do not smoke and have not smoked any tobacco products such as cigarettes, cigarillos or pipe, nor consumed any drugs during the past twelve (12) months." It is understood that SSQ, Life Insurance Company Inc., may periodically require a confirmation of the non-smoker status. A failure to provide this information shall result in the insured person's loss of non-smoker status, and the associated premium reduction shall cease to apply as of the date of the request by SSQ, Life Insurance Company Inc. I also acknowledge that a false or incomplete declaration may result in coverage becoming null and void.

For yourself
6.1 Date: (Y M D)
6.2 Participant's signature:

For your spouse
6.3 Date: (Y M D)
6.4 Spouse's Signature:

7 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 the insurer to use the information contained on this form, including my Social Insurance Number, for administrative purposes. I certify that all of the information I have provided on this form is true and complete. 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.

7.1 Date: (Y M D) 7.2 Participant's signature

8 SSQ Section

N° groupe	N° certificat	En vigueur (A M 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 ☐
Conjoint fumeur ☐
Codifié par _____ le _____
Code certificat

White copy for SSQ — Yellow copy for CARRA — Pink copy for the Employer — Orange copy for the Participant.

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CHOICE OF COVERAGE

Note 1

Optional Additional Life Insurance - Add or remove

In the "Add" or "Remove" column, enter the total number of units you wish to have and not the number of units you are adding or subtracting. For example, if you have 3 times your salary and you indicate "2" on the "Decrease to" line of the "Remove" column, we will subtract 1 times your annual salary from your amount of additional life insurance.

EMPLOYMENT STATUS

Note 2

When filing an application form, depending on the sector in question, the employment letter, the appointment or tenure certificate or the appointment letter must be attached to the yellow copy for the CARRA. These documents must be sent to the following address:

Commission administrative des régimes de retraite et d'assurances (CARRA)

Operations Department
475 Saint-Amable St.
Quebec QC G1R 5X3

For more information about this form or the documents required, contact a pension agent at one of the following numbers:

418-643-4640
1-866-627-2505 ▶ extensions 2382 or 2383

Note 3

The form must be signed by the authorized representative of the employer, according to the legal provisions to that effect, or by the designated individual, if there has been a delegation of signing authority.

NOTICE

File and personal information

To maintain the confidentiality of personal information, SSQ, Life Insurance Company Inc., will create an insurance file to hold information about your application for insurance along with information about any insurance claims you make.
Access to this file will be restricted to thoses employees or authorized agents in charge of underwriting, investigations and claims, and any other person you may authorize. Your file will be in SSQ's offices. You will have the right to consult the personal information held in your file and, if necessary, to have this information rectified by submitting a request in writing to the following address:

Personal Information Protection Officer

SSQ Life Insurance Company Inc.
2525 Laurier Blvd.
P.O. Box 10500, Station Sainte-Foy, Quebec QC G1V 4H6

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.

NEW POSITION

Note 4

If the employer is an association of managers, of senior management or employers, or if the individual is employed by an employer whose personnel is not appointed in accordance with the Civil Service Act, please enclose the following with your form:

- a description of your job
- your organizational structure