



1 IDENTIFICATION OF PARTICIPANT			
Last Name		First Name	
Social Insurance Number			
2 GENERAL INFORMATION			
Address			
Postal Code		Email	
Telephone (work)		Telephone (home)	
Date of Birth		Gender	
Language Preference			
3 PLANS			
APPLICATION		CHANGE (complete "Event" section if necessary)	
HEALTH INSURANCE PLAN			
COMPULSORY BASIC PLAN (See notes 1 and 2 over)		* Employer must complete Section 5 relating to exemption.	
<input type="checkbox"/> Individual <input type="checkbox"/> Single-parent <input type="checkbox"/> Family <input type="checkbox"/> Exemption* <input type="checkbox"/> Package 1 <input type="checkbox"/> Package 2 <input type="checkbox"/> Package 3 <input type="checkbox"/> Package 4		<input type="checkbox"/> Individual <input type="checkbox"/> Single-parent <input type="checkbox"/> Family <input type="checkbox"/> Exemption* <input type="checkbox"/> Package 1 <input type="checkbox"/> Package 2 <input type="checkbox"/> Package 3 <input type="checkbox"/> Package 4	
DENTAL CARE INSURANCE			
OPTIONAL (See note 3 over) Minimum duration of participation: 48 months		<input type="checkbox"/> Individual <input type="checkbox"/> Single-parent <input type="checkbox"/> Family <input type="checkbox"/> I want to remove this coverage	
LONG TERM DISABILITY INSURANCE			
COMPULSORY		<input type="checkbox"/> Waiver (See note 4 over)	
LIFE INSURANCE - See note 5 over			
PARTICIPANT'S BASIC LIFE INSURANCE (Compulsory with right to opt out)		<input type="checkbox"/> \$10,000 <input type="checkbox"/> \$25,000 <input type="checkbox"/> I do not want the above \$10,000 coverage	
PARTICIPANT'S OPTIONAL LIFE INSURANCE (Optional participation)		From one (1) to nine (9) units of \$25,000 _____ units of \$25,000 (Indicate total number of units requested)	
DEPENDENT'S BASIC LIFE INSURANCE (Optional participation)		From one (1) to nine (9) units of \$25,000 _____ units of \$25,000 (Indicate total number of units requested)	
DEPENDENT'S OPTIONAL LIFE INSURANCE (Optional participation)		From one (1) to ten (10) units of \$10,000 _____ units of \$10,000 (Indicate total number of units requested)	
SPOUSE'S OPTIONAL LIFE INSURANCE (Optional participation)		From one (1) to ten (10) units of \$10,000 _____ units of \$10,000 (Indicate total number of units requested)	
DESIGNATION OF SPOUSE			
Last Name		First Name	
Date of Birth		Gender	
EVENT justifying the request for change. Indicate date of the event			
(For cohabitation, indicate start date)			
1. Cohabitation (common-law) <input type="checkbox"/>			
→ Was a child born of this union?			
→ If yes, child's date of birth			
→ 1.2 Start date of cohabitation			
2. Marriage or civil union <input type="checkbox"/>			
3. Adoption <input type="checkbox"/>			
4. Birth <input type="checkbox"/>			
5. Custody of a child <input type="checkbox"/>			
6. Death <input type="checkbox"/>			
7. Separation or divorce <input type="checkbox"/>			
8. Termination of spouse's or dependent children's insurance <input type="checkbox"/>			
9. Regular employment status obtained <input type="checkbox"/>			
10. Eligibility to spouse's insurance <input type="checkbox"/>			

BENEFICIARY (life insurance)
 *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.

The insured amount will be payable to the participant's estate OR I designate as a beneficiary in the event of my death:

Last Name and First Name of each beneficiary	Relationship to the participant		%	Beneficiary revocability		Date of birth (if underage child)
	Legal spouse *	Common-law spouse		Other	Revocable	
	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	Y Y Y Y M M D D
	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	Y Y Y Y M M D D
	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	Y Y Y Y M M D D

If you wish to designate more than three (3) beneficiaries, be sure to clearly indicate them in the boxes above (you can list more than one beneficiary per box).
 In this document, SSQ designates SSQ, Life Insurance Company Inc.



APPLICATION FOR INSURANCE
REQUEST FOR CHANGE

► Complete all sections that apply (Section 1 must be completed)

5 Employer				
Name of Organization		Establishment No.		Group No.
Employee No.		Date of Employment	Date of Eligibility	Date Received from Employee
				Date the contract was signed
Absence from work				Employment Category
Is the participant currently absent from work?				Teacher <input type="checkbox"/>
<input type="checkbox"/> No <input type="checkbox"/> Yes If yes, reason _____				Nurse <input type="checkbox"/>
Start date of absence				Support <input type="checkbox"/>
				Professional <input type="checkbox"/>
The participant has:				Support (Ch. 10, adult education) <input type="checkbox"/>
<input type="checkbox"/> maintained participation in all insurance plans held				Other <input type="checkbox"/>
<input type="checkbox"/> maintained participation in the Health Insurance Basic Plan and Complementary Packages held				Employment Status
<input type="checkbox"/> maintained participation in the Health Insurance Basic Plan only				Full time <input type="checkbox"/> Part time <input type="checkbox"/>
				► _____ % of full-time
I certify that this information is complete and accurate.		ANNUAL SALARY ACCORDING TO COLLECTIVE AGREEMENT (as though 100% of full time) \$ _____ / year		
Date		Reserved for health sector		
Telephone No. _____ Ext. _____		During the reference period, the participant has worked 25% or less of full-time and has decided:		
Name of Employer's Representative (in block letters)		<input type="checkbox"/> to participate in the life insurance and disability insurance plans under the collective agreement.		
Signature of Employer's Representative		<input type="checkbox"/> not to participate in the life insurance and disability insurance plans under the collective agreement.		
Exemption from the Health Insurance Plan				
<input type="checkbox"/> Start of exemption _____ → Keep proof of the insurance allowing the exemption.				
<input type="checkbox"/> End of exemption End date of exemption _____ → 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:	Participant's Signature

7 RESERVED FOR SSQ																					
N° groupe		N° certificat				En vigueur			Classe		Adhérent sélection										
J						année mois jour					Non <input type="checkbox"/> Oui <input type="checkbox"/>										
MAL.		FRAIS DENT.		I.H.		R.I.P.		VIE		M.M.A.		VIE		M.M.A.		VIE		M.M.A.		RENTES SURV.	
												P.A.C.		CONJOINT		ENFANTS					
BASE																					
ADD.																					
Adhérent(e) fumeur(se) Oui <input type="checkbox"/> Non <input type="checkbox"/>										Codifié par _____		Code certificat									
Conjoint(e) fumeur(se) Oui <input type="checkbox"/> Non <input type="checkbox"/>																					

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. More information is available in the "Participation in Insurance" subsection of the General Information section of the booklet.

Participation in the Basic Health Insurance Plan is a prerequisite for participation in one or more of the Optional Complementary Packages. If you are exempted from participating in the Basic Plan, you cannot participate in any of the complementary packages.

Note 2

The participant can **participate in one or many complementary packages**. However, when he or she chooses a plan, he or she must complete the **minimum participation period of 24 months**. Each plan has its own minimum participation period of 24 months.

The participant is allowed to **increase his or her Health Insurance coverage at any time**, without the requirement for evidence of insurability or life event. The increase in coverage under the Health Insurance plan will be effective on the first day of the pay period following the date the request is received by the employer.

Certain events in life render you eligible to increase, decrease or terminate your coverage without the requirement for evidence of insurability, provided the request for change is received in accordance with contract provisions. For eligible life events, please refer to the Group Insurance plan booklet.

Note 3

The participant may choose a coverage status (Individual, Single-Parent or Family) different than that for Health Insurance.

The minimum duration of participation in the Dental Care Plan is 48 months.

Note 4

The participant must complete the "Long Term Disability Insurance Exemption or Waiver Privilege" (FV3783A) form and meet the conditions mentioned.

Note 5

Life Insurance stipulates that a minimum of \$10,000 in Participant's Basic 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 Basic Life Insurance is granted comes into force, to make a request to opt out under the provisions of the contract.

Coverage for \$25,000 for Participant's Basic Life Insurance and for Participant's Optional Life Insurance is optional.

Participation in the amount of \$25,00 in Participant's Basic Life Insurance is required to apply for Participant's Optional Life Insurance.

Please note that coverage for amounts of \$10,000 and \$25,000 in Participant's Basic Life Insurance, and for the two first units of \$25,000 for Participant's Optional Life Insurance 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 the two first units of \$25,000 for Participant's Optional Life Insurance as well as any amounts for Spouse's Optional Life Insurance always require that evidence of insurability be presented to SSQ.

Participation in the amount of \$20,00 for the spouse in the Option 2 of Dependents Basic Life Insurance is required to apply for Spouse's Optional Life Insurance.

NOTICE OF CONSTITUTION OF A FILE AND PERSONAL INFORMATION USE

Notice of constitution of a file

The protection of the personal information that we obtain through our activities is very important to SSQ Insurance. This is why, to maintain the confidentiality of personal information, SSQ Insurance (SSQ, Life Insurance Company Inc., SSQ Insurance Company Inc., SSQ Distribution Inc. and their subsidiaries) will create an insurance file to contain your personal information. The information we collect in different instances, including insurance applications, renewals, modifications or claims, will be added to your file. Except for certain exceptions stipulated by law, access to this file is restricted to those SSQ Insurance employees, service providers, agents or any other person you may authorize to access this information when required to fulfill their contract or mandate.

This file is kept at SSQ Insurance's offices or authorized third-party premises. You have the right to consult the personal information held in your file and, if necessary, have it changed by submitting a written request to the Personal Information Protection Officer at the following address:

Personal Information Protection Officer

SSQ Insurance, 2525 Laurier Boulevard, P.O. Box 10500, Stn Sainte-Foy, Quebec City QC G1V 4H6

Collection and use of your personal information

SSQ Insurance only collects information that is necessary for the management and administration of the business relationship we have with you and any other information obtained through your interactions with us.

The personal information we collect, store and use allows us to verify your identity, validate your eligibility for our products and services, estimate insurance risk, determine premiums, process your claims, manage your file and meet legal requirements. It also may be used to improve our products, services, campaigns and promotions based on statistical analyses. If you have given us your social insurance number, it will only be used for administrative and fiscal purposes.

To learn more about our personal information protection practices, go to www.ssq.ca.