SSQ insurance

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 Postal Code	1.6 Telephone (at work)

1.7 Email	1.8 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 Cerificate 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. BEGINNING OR TERMINATION OF SPOUSE'S INSURANCE ☐

2 Plans

2 Plans	2A - Application	2C - Change ▼ 2.C.A. ADD	2C - Change ▼ 2.C.R. REMOVE
• You must select a coverage status from the following:	IND / SINGLE-PARENT / FAM / EXEMPTION	IND / SINGLE-PARENT / FAM / EXEMPTION	IND / SINGLE-PARENT / FAM / EXEMPTION
	2.A.1 / 2.A.2 / 2.A.3 / 2.A.4	2.C.A.1 / 2.C.A.2 / 2.C.A.3 / 2.C.A.4	2.C.R.1 / 2.C.R.2 / 2.C.R.3 / 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)

3 Beneficiary: life insurance

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: compulsory accident and health insurance plan, survivor's pension plan.

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

Note: To be entitled to the survivor's pension plan, it must be provided for in the participant's working conditions or be pursuant to decree.

5 Employer

5.1 Employee No.	5.2 Retraite Québec Employer No	5.3 Received from the employee (Y M J)	5.4 Start Date (Y M J)	5.5 Group No. (See note 3 on back)	
				5.5.1 SSQ No.	5.5.2 CISSS ou CIUSSS (SSS) No.

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

5. 10 Employment status

5.10.1 Permanent ☐
5.10.2 Temporary / Eligible ☐
5.10.3 Casual ☐
5.10.4 Full-time ☐
5.10.5 Part-time ☐
5.10. 6 _____ %

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

5.11.1 Title or occupation of the participant:
5.11.2 Basic annual salary: $
5.11.3 Date of beginning of the participant's absence (Y M D)
5.11.4 Salary category

5.12 Is the employee entitled to maintain the insurance coverage under the group plan for Management personnel of the Quebec public and parapublic sectors ☐ No ☐ Yes
(For employers of the public sector only. See Note 4 on back.)

5.13 Existing Position ▶ ☐ No ☐ Yes
5.13.1 If no = Create new position
5.13.2 If so, which manager stepped down when this position was taken?
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 2 and 3 on back)**

5.15 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, electronic cigarettes (vaporizers), 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 Mandatory 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 Retraite Québec — 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

Attach to the application form, depending on the sector in question, the employment letter, the appointment certificate, the appointment letter, the description of work tasks and the organisation chart must be attached to the yellow copy for the Retraite Québec. These documents must be sent to the following address:

Retraite Québec
P.O. Box 5500, succursale Terminus
Quebec (Québec) G1K 0G9

For more information about section 5 of this form, contact Retraite Québec at one of the following numbers:

418-643-4640 extensions 2382 or 2383
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.

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

HEALTH AND SOCIAL SERVICES SECTOR GROUP NUMBERS

Note 3

As part of the application of the Act to modify the organization and governance of the health and social services network (Bill No. 10), employers from the health and social services sector must indicate, during the transition period, the group number normally used when communicating with SSQ (box 5.5.1) AND the new grouped institution (CISSS or CIUSSS) number (box 5.5.2).
Box 5.5.2 is therefore intended ONLY for health and social services sector (SSS) employers.

List of CISSS and CIUSSS group numbers

CISSS or CIUSSS No.	Name of new grouped institution
ZA010	CISSS du Bas-Saint-Laurent
ZA020	CIUSSS du Saguenay-Lac-St-Jean
ZA030	CIUSSS de la Capitale-nationale
ZA040	CIUSSS de la Mauricie-et-du-Centre-du-Québec
ZA050	CIUSSS de l'Estrie-Centre hospitalier universitaire de Sherbrooke
ZA060	CIUSSS de l'Ouest-de-l'Île-de-Montréal
ZA070	CIUSSS du Centre-Ouest-de-l'Île-de-Montréal
ZA080	CIUSSS du Centre-Est-de-l'Île-de-Montréal
ZA090	CIUSSS du Nord-de-l'Île-de-Montréal
ZA100	CIUSSS de l'Est-de-l'Île-de-Montréal
ZA110	CISSS de l'Outaouais
ZA120	CISSS de l'Abitibi-Témiscamingue
ZA130	CISSS de la Côte-Nord
ZA140	CISSS de la Gaspésie
ZA150	CISSS des Îles
ZA160	CISSS de Chaudière-Appalaches
ZA170	CISSS de Laval
ZA180	CISSS de Lanaudière
ZA190	CISSS des Laurentides
ZA200	CISSS de la Montérégie-Centre
ZA210	CISSS de la Montérégie-Est
ZA220	CISSS de la Montérégie-Ouest

MANAGEMENT PERSONNEL OF THE PUBLIC SECTOR

Note 4

All departments and agencies whose personnel is appointed in accordance with the Public Service Act are included in the public sector (CQLR, chapter F-3.1.1)