SSQ Financial Group

VOLUNTARY CRITICAL ILLNESS APPLICATION FORM

PARTICIPANT TO COMPLETE

Identification of Participant

Last Name	First Name	Gender ☐M ☐F	Date of Birth Y M D
Address		Employee No.	Work Tel.
Town/City	Province	Postal Code	Home Tel.

Voluntary Critical Illness	Application	Change	
	☐ Applying for	☐ Increase	☐ Decrease
Participant	Total amount	Current amount Additional amount Total amount	Current amount Withdrawn amount Total amount
Spouse[1]	Total amount	Current amount Additional amount Total amount	Current amount Withdrawn amount Total amount
Child(ren)	Total amount	Additional amount	Withdrawn amount

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.

"Non-smoker" means a person who has not smoked any cigarettes, cigarillos, cigars, marijuana, used pipes, chewed tobacco or used any nicotine products (patch, gum, etc.) within the past 12 months.

PARTICIPANT: Non-smoker ☐ _____ Signature of Participant

SPOUSE: Non-smoker ☐ _____ Signature of Spouse

[1] An insured cannot enroll in the Voluntary Critical Illness plan as both a participant and a spouse.

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, 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				Policy No.
Date of employment Y M D	Date of eligibility Y M D	Date form submitted by Participant to Plan Administrator Y M D	Participant's guaranteed issue amount	Spouse's guaranteed issue amount

Please check the box below which applies to this request and follow the instructions.

Application or Request for change - Increase

- ☐ If your policy provides for a guaranteed issue amount and the requested amount is equal or less, you must put the coverage into effect at the date of eligibility and deduct the premium. You do not have to notify SSQ. Please keep the form for your file.
- ☐ If your policy provides for a guaranteed issue amount and the requested amount is greater, you must put into effect an amount equal to the guaranteed issue amount at the date of eligibility and deduct the premium. In order to obtain the excess amount of the guaranteed issue amount, please fax the form to the Medical Underwriting Department at 1-866-720-9640.
- ☐ If your policy provides for a guaranteed issue amount and the proposed insured is not eligible, as he is a late applicant, please fax the form to the Medical Underwriting Department at 1-866-720-9640.
- ☐ If your policy does not provide for a guaranteed issue amount, please fax the form to the Medical Underwriting Department at 1-866-720-9640.

If the form must be faxed to the Medical Underwriting Department

No other form is to be completed by the participant or the spouse. The Medical Underwriting Department will contact the proposed insured directly to begin the medical underwriting process. We kindly ask you to notify your employee accordingly. You will be informed of the decision in a decision report that will be sent to the Plan Administrator mentioned beside. If the coverage is granted, you must put the coverage into effect at the effective date according to the policy and deduct the premium.

Request for change - Decrease

- ☐ You must make the change and adjust the premium. You do not have to notify SSQ. Please keep the form for your file.

I certify that all information above is true and complete.

Date Y M D

_____ Name (please print)

_____ Signature of Plan Administrator

Tel. _____ Ext. _____

Email of Plan Administrator _____

SSQ, INSURANCE COMPANY INC.
MEDICAL UNDERWRITING DEPARTMENT
PHONE NO.: 1-866-622-4776 • FAX NO.: 1-866-720-9640
medicalunderwriting@ssq.ca

PERSONAL INFORMATION PROTECTION

To safeguard the confidentiality of your personal information, SSQ, 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, Insurance Company Inc.
2525 Laurier Boulevard
P.O. Box 10500, Station Sainte-Foy
Quebec QC G1V 4H6

SSQ, 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.