SSQ insurance

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

Telephone (work) | Telephone (home) | Date of Birth (Y Y Y Y M M D D) | Gender M ○ F ○ | Language Preference Fr. ○ En. ○

3 PLANS

	APPLICATION	CHANGE (complete "Event" section if necessary)
HEALTH INSURANCE PLAN		
COMPULSORY BASIC PLAN (See notes 1 and 2 over)	☐ Individual ☐ Single-parent ☐ Family ☐ Exemption* * Employer must complete Section 5 relating to exemption.	☐ Individual ☐ Single-parent ☐ Family ☐ Exemption* * Employer must complete Section 5 relating to exemption.
OPTIONAL COMPLEMENTARY PACKAGES **Minimum duration of participation: 24 months**	☐ Package 1 ☐ Package 2 ☐ Package 3 ☐ Package 4	ADD: ☐ Package 1 ☐ Package 2 ☐ Package 3 ☐ Package 4 REMOVE: ☐ Package 1 ☐ Package 2 ☐ Package 3 ☐ Package 4
DENTAL CARE INSURANCE		
OPTIONAL (See note 3 over) **Minimum duration of participation: 48 months**	☐ Individual ☐ Single-parent ☐ Family	☐ Individual ☐ Single-parent ☐ Family ☐ I want to remove this coverage
LONG TERM DISABILITY INSURANCE		
COMPULSORY	☑ Compulsory participation	☐ Waiver (See note 4 over)
LIFE INSURANCE - See note 5 over		
PARTICIPANT'S BASIC LIFE INSURANCE (Compulsory with right to opt out)	☑ $10,000 **automatic coverage upon registration** ☐ $25,000 ☐ I do not want the above $10,000 coverage	☐ $10,000 ☐ $25,000 ☐ I wish to remove this coverage in accordance with my right to opt out of the minimum compulsory amount of $10,000
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)	**From one (1) to nine (9) units of $25,000** _____ units of $25,000 (Indicate total number of units requested) ☐ I want to remove this coverage
DEPENDENT'S BASIC LIFE INSURANCE (Optional participation) **Option 1** Spouse: $10,000 Per child: $5,000 **Option 2** Spouse: $20,000 Per child: $10,000	(Check only one box to indicate the desired coverage) **Option 1:** ☐ Spouse ☐ Dependent children ☐ Spouse and dependent children **Option 2:** ☐ Spouse ☐ Dependent children ☐ Spouse and dependent children	(Check only one box to indicate the desired coverage) **Option 1:** ☐ Spouse ☐ Dependent children ☐ Spouse and dependent children **Option 2:** ☐ Spouse ☐ Dependent children ☐ Spouse and dependent children ☐ I want to remove this coverage
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)	**From one (1) to ten (10) units of $10,000** _____ units of $10,000 (Indicate total number of units requested) ☐ I want to remove this coverage

DESIGNATION OF SPOUSE

Last Name | First Name | Date of Birth (Y Y Y Y M M D D) | Gender M ○ F ○

EVENT justifying the request for change. Indicate date of the event (Y Y Y Y M M D D)

(For cohabitation, indicate **start date**)

1. Cohabitation (common-law) ☐
   - → 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. Death ☐
7. Separation or divorce ☐
8. Termination of spouse's or dependent children's insurance ☐
9. Regular employment status obtained ☐
10. Eligibility to spouse's insurance ☐

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: Legal spouse *	Common-law spouse	Other	%	Beneficiary revocability: Revocable	Irrevocable	Date of birth (if underage child)
	☐	☐			☐	☐	(Y Y Y Y M M D D)
	☐	☐			☐	☐	(Y Y Y Y M M D D)
	☐	☐			☐	☐	(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.

CSQ alter ego

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. 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 participation in all insurance plans held

☐ maintained participation in the Health Insurance Basic Plan and Complementary Packages held

☐ maintained participation in the Health Insurance Basic Plan only

Employment Category

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

Employment Status

Full time ○ Part time ○

▶ _____ % of full-time

I certify that this information is complete and accurate.

Date (Y Y Y Y M M D D)

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 (année mois jour) | 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 _____ (Y Y Y Y M M D D)

Code certificat

FV3359A (2021-02)

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.