SSQ Financial Group

Request for Optional Life Insurance

PLEASE COMPLETE THIS FORM IN BLOCK LETTERS USING INK

A. Employer Information

Policy Holder Name _____ SSQ Group # _____

Division Name _____ Certificate # _____

B. Participant Information

Last Name _____ First Name _____ Social Insurance Number _____

Mailing Address _____ Postal Code _____

Telephone (Home) _____ Telephone (Work) _____ Date of Birth Y Y Y Y M M D D $ _____ Salary

Gender: ☐ Female ☐ Male Language Preference: ☐ English ☐ French

C. Request for Optional Life Insurance Coverage

IMPORTANT: Option Life Insurance units of $10,000 are only available to plans that currently offer this benefit.

Participant (Please check N/A if request is only for spouse)		**Spouse**	
Current amount of coverage (in force)	Additional amount of coverage (requested)	Current amount of coverage (in force)	Additional amount of coverage (requested)
☐ None ☐ 1x salary ☐ 2x salary ☐ 3x salary _____ units of $10,000	☐ N/A ☐ 1x salary ☐ 2x salary ☐ 3x salary _____ units of $10,000	☐ None ☐ 25% _____ units of $10,000	☐ 25% ☐ 50% _____ units of $10,000
Spouse	Last Name _____ First Name _____		
	Gender: ☐ Female ☐ Male	Date of Birth Y Y Y Y M M D D	

D. Smoking Habits

Participant: ☐ Non-Smoker ☐ Smoker **Spouse:** ☐ Non-Smoker ☐ Smoker

"I declare that I do not smoke and have not smoked any tobacco products such as cigarettes, cigars, cigarillos or pipes, or any drugs during the past 12 months. This statement is an affirmative guarantee on my part." It is understood that the insurer may periodically require confirmation of non-smoker status. The participant must be in a position to meet the requirements then in force and return the confirmation within 30 days of the request, failing which the participant shall lose non-smoker status and the associated premium reduction shall cease to apply as of the date of the insurer's request. "I also acknowledge that a false or incomplete statement may cause the coverage to be null and void."

Participant _____ Spouse _____

E. Beneficiary

The optional amount insured will be payable to my estate ☐

OR

I wish to designate the following beneficiary(ies) in the event of my death: Beneficiary Name(s):

Last Name	First Name	Relationship to Participant

This beneficiary designation is*:

☐ Revocable (beneficiary designation may be changed at any time)
☐ Irrevocable (beneficiary designation can only be changed with the written consent of the designated beneficiary(ies)

* In Quebec, when no beneficiary status is specified, designation of the legal spouse is **irrevocable** and designation of any other beneficiary is **revocable**.

F. Participant Authorization

I hereby authorize my employer to deduct from my salary the premiums for the coverage I have chosen. I hereby authorize my employer and the insurer to use the above information and my social insurance number, for administrative purposes. I hereby certify that all above information is true and complete.

Name (Please Print)	Signature	Date Signed
		Y Y Y Y M M D D

G. Employer Authorization

Participant's Date of Employment: Y Y Y Y M M D D

Participant is actively at work as of date of application for Optional Life Insurance coverage: ☐ Yes ☐ No

Optional Life request in accordance with policy provisions: ☐ Yes ☐ No

Name of Plan Administrator (Please Print)	Signature	Date Signed
		Y Y Y Y M M D D