SSQ Financial Group

OJTBF Not For Profit Group Benefits

REQUEST FOR CHANGE

PARTICIPANT TO COMPLETE

Identification of the Participant

Last Name	First Name	Group No.	Certificate No.

COMPLETE ONLY THOSE SECTIONS TO BE CHANGED

Health and Dental Care Insurance

(Also complete Spouse and Dependent Children section)

Effective date of change: Y M D

Change to: Health Insurance ◯ Individual ◯ Family ◯ None. I am covered under my spouse's plan.
Dental Care Insurance ◯ Individual ◯ Family ◯ None. I am covered under my spouse's plan.

Spouse and Dependent Children

Add ◯ Remove ◯ Change ◯ Effective date: Y M D

Spouse's last name: _____ First name: _____ Date of birth: Y M D Gender: ◯ M ◯ F

What type of Health Insurance coverage does your spouse have under another policy? ◯ Individual ◯ Family ◯ None

What type of Dental Care Insurance coverage does your spouse have under another policy? ◯ Individual ◯ Family ◯ None

First and last name of child	Gender	Date of birth	Does the child have a disability?	Is the child a full-time student?	Name of educational institution
	◯ M ◯ F	Y M D	◯ Yes ◯ No	◯ Yes ◯ No	
	◯ M ◯ F	Y M D	◯ Yes ◯ No	◯ Yes ◯ No	
	◯ M ◯ F	Y M D	◯ Yes ◯ No	◯ Yes ◯ No	
	◯ M ◯ F	Y M D	◯ Yes ◯ No	◯ Yes ◯ No	

Optional Life Insurance

	Participant	Spouse
Current amount of Optional Life Insurance (1) (2)	$	$
Additional amount of Optional Life Insurance being requested (1) (2)	$	$
	TOTAL $	$

Notes:
(1) Optional Life Insurance: Do not include the amount of Basic Life Insurance coverage.
(2) Optional Life Insurance: This coverage may not be available under your group insurance plan. Please check with your plan administrator.

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.
"I understand that to be considered a non-smoker, I must not have smoked during the twelve (12) months prior to the application for insurance. I understand that the insurer may periodically require confirmation of non-smoker status; in such case I must be able to meet the requirements in force at that time and return confirmation within 30 days of the insurer's request, failing which I will no longer benefit from non-smoker status and the associated reduction in premiums, effective as of the date of the insurer's request."

PARTICIPANT: Non-smoker ◯ _____ Signature of Participant **SPOUSE:** Non-smoker ◯ _____ Signature of Spouse

Beneficiary

OR **The amount insured will be payable to my estate** ◯

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

Name(s): _____ **Relationship:** _____

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.

If you designate more than one beneficiary, the insurance proceeds will be distributed evenly between them unless you specify the percentage of the insurance you wish to allocate to each beneficiary.

I hereby appoint (full name, relationship) _____ as Trustee to receive any amount payable to a minor beneficiary under this policy and declare the receipt by such Trustee shall discharge the Insurance Company for the amount so paid. And I do hereby authorize the Trustee, within his/her discretion, to expend all or any such amount and/or the income resulting from the proceeds for the maintenance or education of such minor. (You must appoint a trustee if your beneficiary is under age 18.)

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, INCLUDING MY SOCIAL INSURANCE NUMBER, 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 participating employer	Date form submitted by employee to employer
	Y M D

I certify that all information above is true and complete.

_____ Date _____ Name (please print)

Tel. _____ Ext. _____ _____ Signature of Plan Administrator

WHITE COPY FOR ADMINISTRATOR • YELLOW COPY FOR PARTICIPANT

PERSONAL INFORMATION PROTECTION

To safeguard the confidentiality of your personal information, SSQ, Life 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, Life Insurance Company Inc.
110 Sheppard Avenue East
Suite 500
Toronto, ON M2N 6Y8

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.