

PARTICIPANT COMPLETES SECTIONS 1-2-3-7, AND 4 AND 6 IF NECESSARY EMPLOYER COMPLETES SECTION 5

SECTION 8 FOR USE OF SSQ ONLY

P.O. Box 10500, Station Sainte-Foy, Quebec QC G1V 4H6

1 IDENTIFICATION OF PAR	RTICIPANT											
1.1 Last Name		1.2 Fir	st Name						1.3	Social In	suranc	e Number
2 GENERAL INFORMATION	N									1		
2.1 Address											2.2 Po	stal Code
2.3 Telephone (at work)	2.4 Telephone (at home)			2.5 Birt		M		2.6 G	iender		2.7 La	nguage Preferen
								М	F		Fr.	Eng.
DESIGNATION OF SPOU	SE											
								Y	N	1 D		
Last Name	First Na	me					Birt	ו Date				M F Gender
3 PLANS			APPLI	CATI	ON				СН	ANGE	1	
	,	Ind	Single-Parent			Ind	Single	-Paront		Exempt		
3.1 HEALTH INSURANCE PLAN (compuls You must choose only one of the follow	•		Single Fulche	T unit.	Exemption		Singi	. i urent	rum.	Exempt	ion	
Basic Health Insurance												
Intermediate Health Insurance												
Superior Health Insurance												
(See Notes 1, 2, 3 and 4)												
3.2 DENTAL CARE INSURANCE PLAN (op	otional)	Ind.	Single-Parent	Fam.	Exemption*	Ind	. Single	e-Parent	Fam.	Exempt	ion*	Removal
(See Notes 1, 2, 3 and 4)												
3.3 COMPLEMENTARY PLAN I (compulso	orv)											
a) Participant's Basic Life Insurance			Compulsory	Waiver (see Note 5)								
(1 X gross annual salary)							INCRE/				DE	DEACETO
b) Participant's Optional Life Insurat (1, 2 or 3 X gross annual salary)	nce		times (indi	cate tota	l number	ti			umher	DECREASE TO times (indicate total number		
(1, 2 of 3 × gross annual salary) (See Note 7)			of times				times (indicate total number of times requested)				of times requested)	
c) Spouse's and Dependent Childrei	n's Life Insurance		Compulsory	(see N	lote 6)			Con	npulsor	y (see No	ote 6)	
d) Spouse's Optional Life Insurance							INCRE/	ASE TO			DEC	CREASE TO
(1 to 10 units of \$10,000) (See Note 7)					f \$10,000		unit(s) of \$10,000				unit(s) of \$10,000	
			(indicate desired			(indicat	e desired r	number of				ired number of units
 e) Long Term Disability Insurance * Section 5.13 must be completed by t 	ha amplayar		Comp	oulsory				Right	to opt o	out (see l	Note 8)
section 5.15 must be completed by t	ne employer.											
EVENT justifying the request for change. Inc	dicate the date of the event (For ite	ms 2 to 8)	Y	M	D						
(For cohabitation, indicate start date)												
			2. MARRIAGE				5. SEPAR					
(common-law)			3. ADOPTION	N			7. DIVOR					
1.1 Was a child born of the union?	Y M D		4. BIRTH					NATION SE'S LIFE				
If yes, child's birth date :			5. CUSTODY	OF A CI	HILD		51 00.	5E 5 Ell E	11130101	INCL.		
4 BENEFICIARY												
Name of the beneficiary(ies):												
I hereby designate as my beneficiary in the eve	ent of my death:											
Spouse (married or civil union) (1) Commo	on-law spouse (7) Son(s)/	/daugł	nter(s) (2) Sp	oouse (I	married or civil	union) and	l son(s)/o	daughte	r(s) (6)	Fathe	r-moth	ier (3)
Common-law spouse and son(s)/daughter(s) (8) Brother(s)/sister(s) (4)											
	hanged at any time)					[* Unde	r Queb	ec law,	when n	o ben	eficiary status i
· · · ·	hanged only with written cor	nsent o	of irrevocable be	eneficia	ry)							ed or civil union ion of any othe
OR								se is irre ficiary is			signat	ion of any othe





5 EMPLOYER									
5.1 NAME OF ORGANIZATION					5.2 ESTABLISHMENT NO.	5.3 GROUP	NO.		
						X			
5.4 EMPLOYEE NO.	5.7 Date receive from emplo		5.8 EMPLOYMENT STATUS AND WAITING PERIOD FOR ELIGIBILITY						
	Y M D	Y M D	Y M	D	 Permanent employee working of full time (1 month) 	70% or more		5.8.1	
			Employee hired under another	employment					
5.9 IS THE PARTICIPANT CURREN	NTLY ABSENT FROM	WORK?			status (3 months)			5.8.2	
					Percentage of time worked		5.8.3	%	
No Yes If yes, reason					5.10 REVISION OF PERCENTAG	E OF TIME WO	ORKED		
5.9.1 Start date of absence					The percentage of time worked by participant has decreased to 25% or less of full time during the reference period. The participant has decided to:				
The participant on unpaid leave	of more than 28 day	/s has chosen to:			5.10.1 D Maintain current coverage (must participate in coverage that is mandatory under the collective agreement)				
5.9.2 Maintain participation in	all insurance plans	currently held			5.10.2 Maintain participation in Health Insurance Plan currently held only				
5.0.2					5.10.3 🗌 Participate in Basic Heal	th Insurance P	lan only		
5.9.3 Maintain participation in	the Health Insuran	ice Plan currently h	ield only		5.11 ANNUAL SALARY ACCORE	DING TO COLI	ECTIVE AGI	REEMENT	
5.9.4 Maintain participation in	the Basic Health Ir	isurance Plan only			(As though 100% of full time) \$ / year				
5.12 I CERTIFY THAT THIS INFORMA	TION IS COMPLETE A	ND ACCURATE.							
					Name of Employer's Representative (in	block letters)			
	F .								
Tel. No. ()	Ext				Signature of Employer's Represe	ntative			
5.13 EXEMPTION (See Note 3)		Health Insurance Plan	n Dental Care In	surar	nce Plan				
5.13.1 Start of exemption —		5.13.2	5.13.	3					
5.13.4 End of exemption —		5.13.5	5.13.	6	Provide proof of insurance termina	tion allowing t	he exemption	n.	
5.14 COMMENTS									

6 NON-SMOKER'S STATEMENT - for Optional Life Insurance

"I, the undersigned, declare that I do not smoke and have not smoked any tobacco products such as cigarettes, cigars, cigarillos, pipes, nor consumed any drugs during the past twelve (12) months. I understand that SSQ may periodically require confirmation of 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 SSQ's request. I also acknowledge that a false or incomplete declaration may result in coverage becoming null and void."

Participant	1.4
6.1 Date:	

6.2 Signature:

7 SIGNATURE

I hereby authorize my employer to deduct from my salary the premiums required for the plans selected. I authorize my employer and SSQ to use the above information, including my Social Insurance Number, for administrative purposes. I certify that the information I have provided on 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.

.1 Date:		7.2 Participant Signature:

8 RES	ERVED	FOR SS	Q												
N° groupe N° certificat					En vigueur Y M D				Clas	Classe		Adhérent sélection			
X														Οι	ui 🗌
		FRAIS					VIE	M.M.A.	VIE	M.M.A.	VIE	M.M.A.	RENTE	s	
	MAL.	DENT.	I.H.	R.I.P.	VIE	M.M.A.	P.À	C.	CONJ	OINT	ENF	ANTS	SURV		
BASE															
ADD.															
Adhérent(e) fumeur(se) Oui Non Code certificat Conjoint(e) fumeur(se) Oui Non Codifié par										tificat					
Conjoint(e	e) fumeur(se) Oui	Non	Codifié par	·					le _					

White copy for SSQ — Yellow copy for Plan Administrator — Pink copy for Participant

CHOICE OF INSURANCE PROTECTION

Note 1

Eligible employees working 25% of full time or less must either participate in the Health Insurance Plan only or participate in all plans, on the condition that they participate in the Life Insurance and Short Term Disability coverage stipulated under the collective agreement, subject to the exemption entitlement.

Retirees who are rehired are not eligible for the APTS Group Insurance Plan.

<u>Note 2</u>

You must choose a coverage status (Individual, Single-Parent, Family or Exemption) for the Health Insurance Plan and, if applicable, for the Dental Care Insurance Plan.

The coverage status combinations **available** are as follows:

Health Insurance Plan	Dental C	Dental Care Insurance Plan (optional)						
(compulsory)	Individual	Single-Parent	Family					
Individual	Yes	No	No					
Single-Parent	Yes	Yes	No					
Family	Yes	Yes	Yes					
Exemption	Yes	Yes	Yes					

Note 3

Start of exemption

In accordance with Quebec's *Act respecting prescription drug insurance*, subject to the exemption entitlement, participation in the Basic Health Insurance Plan is compulsory as it provides prescription drug coverage. Therefore, you may decline or cease participation in health insurance under the condition that you establish that you and any of your dependents, where applicable, are insured under another plan with prescription drug coverage.

For the Dental Care Insurance Plan, participants may exercise their exemption entitlement if they provide proof that they are eligible for a compulsory public sector dental care plan which does not allow exemptions from coverage.

End of exemption

Participants who are exempted from participating in the Health Insurance Plan or Dental Care Insurance Plan may participate at a later date, provided they establish to the satisfaction of SSQ:

- i) that they and their dependents, if any, were previously insured under this insurance plan or under another similar group insurance plan; and
- ii) that it has become impossible for them, and their dependents, if any, to continue to be insured under the plan that allowed the exemption.

Note 4

The minimum duration of participation in the Intermediate Health Insurance, Superior Health Insurance and Dental Care Insurance plans is 48 months, effective as of the initial date of enrolment in the plan.

However, for the Health Insurance Plan, the participant may, on January 1 of each year, choose to participate in a **higher level** plan even if they have not completed the minimum duration of participation of 48 months.

For the rules that apply to the coming into force of these plans and to changes in coverage status, please refer to your insurance plan booklet.

Note 5

A participant may waive Participant's Basic Life Insurance provided he/she already has a minimum of \$25,000 in **individual** life insurance. To do so, the participant must complete the "Request to Waiver Participant's Basic Life Insurance Plan" form (FV4726A) usually available through their employer's Human Resources department and provide proof of this coverage. A participant who waives Basic Life Insurance is not eligible for Participant's Optional Life Insurance. A participant who later wishes to have Participant's Basic Life Insurance must submit a written request to SSQ and enclose evidence of insurability accepted by SSQ.

<u>Note 6</u>

Participation in Spouse's and Dependent Children's Life Insurance is compulsory with the same coverage status as the Health Insurance Plan. Therefore, participants with individual coverage status or an exemption for Health Insurance are not eligible to take out Spouse's or Dependent Children's Life Insurance.

Note 7

Evidence of insurability is always required.

A participant who waives Participant's Basic Life Insurance, is not eligible for Participant's Optional Life Insurance.

Participants may take out Spouse's Optional Life Insurance at any time.

In the "Change" column, enter the number corresponding to the coverage you want and the number of units you wish to add or remove. For example, if you have Optional Life Insurance coverage for 3 times your salary and you enter the number 2 on the line under "Decrease to" in the "Change" column, we will take one unit away from your amount of Optional Life Insurance coverage.

If an application is made for Participant's or Spouse's Optional Life Insurance, the person to be insured must be sure to complete the **non-smoker's statement** included under section 6 if they do not smoke.

Note 8

The participant must complete the "Right to Opt out of Long Term Disability Insurance Coverage" form and meet certain conditions. Please refer to section 1.3.1)c)iii) of the insurance booklet.

NOTICE

Personal Information Protection

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 your file will be restricted to those employees and authorized agents in charge of underwriting, investigations and claims, and any other person you may authorize.

Your file will be kept at SSQ's offices. You 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 Personal Information Protection Policy. To obtain a brochure outlining this policy, send a request in writing to SSQ's Personal Information Protection Officer at the address provided above.