

PARTICIPANT SECTION

Identification of the Participant

Last Name	First Name	Social Insurance Number
-----------	------------	-------------------------

General Information

Address		Telephone (work)	
Town/City	Province	Telephone (home)	
Postal Code	Date of Birth	Language Preference	Gender
	Y M D	<input type="radio"/> English <input type="radio"/> French	<input type="radio"/> M <input type="radio"/> F

PARTICIPANT SECTION

Coverage

You must select one of the following types of coverage (even if requesting an exemption)

Health insurance and dependents' life insurance (compulsory)	INDIVIDUAL	FAMILY	SINGLE-PARENT	COUPLE
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Exemption requested for health insurance (I am already insured under another private plan.)

With this form please enclose proof that you are insured under another private plan. The exemption does not apply to dependents' life insurance.

Long term disability insurance (compulsory)

Annual salary: _____

Exemption requested for long term disability insurance (I am already insured under another group or individual plan.)¹

Please enclose with this form the proof of your long term disability insurance coverage under another group or individual insurance plan.

NOTE (1) The decision to opt out of long term disability insurance coverage is irrevocable if you are insured under an individual contract.

Beneficiary

The 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): _____

Relationship to Participant Legal spouse Common-law spouse Legal spouse and son(s)/daughter(s)
 Common-law spouse and son(s)/daughter(s) Son(s)/daughter(s) Father/mother Brother(s)/sister(s) Other

Beneficiary status chosen*:
 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, if no beneficiary status is specified, the designation of the legal spouse is irrevocable and the designation of any other person is revocable.

Signature of Participant

I HEREBY AUTHORIZE THE ARPQ TO WITHDRAW FROM MY BANK ACCOUNT THE PREMIUMS REQUIRED FOR THE COVERAGE I HAVE CHOSEN. I HEREBY AUTHORIZE THE ARPQ AND THE INSURER TO USE THE ABOVE INFORMATION, INCLUDING MY SOCIAL INSURANCE NUMBER, FOR ADMINISTRATIVE PURPOSES. I HEREBY CERTIFY THAT ALL ABOVE INFORMATION IS TRUE AND COMPLETE. I CONFIRM THAT I HAVE READ THE NOTICE ON THE BACK REGARDING MY INSURANCE FILE AND PERSONAL INFORMATION AND HAVE KEPT A COPY OF THIS FORM.

Date: Y | M | D | Signature: _____

PLAN ADMINISTRATOR SECTION

Plan Administrator

Name of organization to be invoiced _____

Group No.	Membership No.	Date of membership in the ARPQ	Date of eligibility	Date application submitted by employee to the ARPQ
		Year Month Day	Year Month Day	Year Month Day

Administrator's Signature

I certify that all information above is true and complete.

_____ Date _____ Name (please print) _____

Telephone _____ Ext. _____ Signature of Plan Administrator _____

Section SSQ

N° groupe		N° certificat		En vigueur			Classe			Adhérent sélection		
				année	mois	jour				Non <input type="radio"/>	Oui <input type="radio"/>	
	MAL.	FRAIS DENT.	I.H.	R.I.P.	VIE	M.M.A.	VIE	M.M.A.	VIE	M.M.A.	RENTES SURV.	
							P.À.C.	CONJOINT	ENFANTS			
BASE												
ADD.												
Adhérent(e) fumeur(se)		OUI <input type="radio"/>	NON <input type="radio"/>								Code certificat	
Conjoint(e) fumeur(se)		OUI <input type="radio"/>	NON <input type="radio"/>	Codifié par _____ le _____								

NOTICE

Personal information and insurance file

To maintain the confidentiality of your personal information, SSQ, Life Insurance Company Inc. will create an insurance and annuity file to hold information about your application for insurance or an annuity, along with information about any insurance claims you make.

Access to this file will be restricted to employees or agents who are responsible for underwriting, investigation and claims, and any other person you may authorize.

Your file will be kept in SSQ's offices in Sainte-Foy, Quebec.

You have the right to consult the personal information held in your file and, if necessary, have this information rectified, by submitting a request in writing to the following address: Personal Information Protection Officer, SSQ, Life Insurance Company Inc., P.O. Box 10500, Station Sainte-Foy, Quebec, QC G1V 4H6.