Supplement to the application
Authorization

SSQ, Life Insurance Company Inc.
1225 Saint-Charles Street West, Suite 200, Longueuil, Quebec J4K 0B9

POLICY NUMBER

APPLICATION N°

AUTHORIZATION

I hereby authorize any doctor, hospital, clinic, insurance company, the MIB Inc. or any other institution or organization holding information about me, including specific information about my state of health, my family medical history, my lifestyle, my finances and my reputation, to communicate this information to SSQ, Life Insurance Company Inc. and to its reinsurers. I also authorize my insurer to exchange any personal information contained in the present application with other insurers, financial security advisors/representatives, financial institution or anyone else I have designated, and to make inquiries with them for the purposes of risk selection, premium calculation or in the event of a claim.

In case of my death, the beneficiary, legal heir or executor of my estate is expressly authorized to communicate to the insurer, when required by it, any and all information or authorizations required for the settlement of the death claim and to obtain any justification requested. As well, SSQ, Life Insurance Company Inc. is permitted to obtain information about me or my state of health and I am willing to undergo any tests, X-rays, electrocardiograms, blood or urine tests which SSQ, Life Insurance Company Inc. may request in order to underwrite my insurance application. Furthermore, I authorize SSQ, Life Insurance Company Inc. to communicate the results of these tests to its reinsurers, and as required, to my attending physician and the MIB Inc. In addition, I authorize SSQ, Life Insurance Company Inc. to include all personal information contained in its existing or future files. A photocopy or an electronic copy of this authorization shall be valid as the original.

NOTE : PLEASE COMPLETE THIS AUTHORIZATION IN BLUE INK.

Name of insured (in capital letters)	**X** Signature of insured	Y Y Y Y M M D D Date
If a minor insured: Name of the mother, father or legal guardian (in capital letters)	**X** Signature of the mother, father or legal guardian (indicate relationship to the insured)	Y Y Y Y M M D D Date

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Name of insured (in capital letters)	**X** Signature of insured	Y Y Y Y M M D D Date
If a minor insured: Name of the mother, father or legal guardian (in capital letters)	**X** Signature of the mother, father or legal guardian (indicate relationship to the insured)	Y Y Y Y M M D D Date

PLEASE ATTACH THIS FORM TO THE APPLICATION.