



Policy reinstatement

Version: May 2022

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

Instructions for advisors

Please complete this form to request a policy reinstatement. A fee of \$25 is applicable for the reinstatement of a universal life insurance policy.

If the policy has more than two insureds, please complete a second form.

If there is more than one policyowner, EACH policyowner must sign Section M of this form.

To request a policy change or reinstatement for accident / sickness insurance products, please complete the appropriate form, either the Policy Change form for Individual Disability Plan (FIND0040A) and/or the Policy Change form for AcciGuard (FIND0039A).

A – General information

Policy number _____

A1 – Proposed Insured(s) (Please write the first name and last name of the insured in capital letters. When the insured and the policyowner are the same person, the insured must be a Canadian resident.)

Insured 1

First and last names _____

Address (civic number, street) _____

City _____ Province _____

Postal code _____

Telephone _____

Insured 2

First and last names _____

Address (civic number, street) _____

City _____ Province _____

Postal code _____

Telephone _____

A2 – Employment details

Insured 1

Profession/Occupation and years of service (current employer) – provide details
(if retired, indicate the last profession and work field) _____

Tasks involved in occupation _____

Nature of employer's business _____

\$ _____ \$ _____
Gross annual income Net worth

\$ _____ → _____
Other income Specify source

Employer's name _____

Civic number and street name _____ Suite number _____

City _____

Province _____ Postal code _____

Telephone (office) _____

Insured 2

Profession/Occupation and years of service (current employer) – provide details
(if retired, indicate the last profession and work field) _____

Tasks involved in occupation _____

Nature of employer's business _____

\$ _____ \$ _____
Gross annual income Net worth

\$ _____ → _____
Other income Specify source

Employer's name _____

Civic number and street name _____ Suite number _____

City _____

Province _____ Postal code _____

Telephone (office) _____

A3 – Policyowner(s)

The policyowner must be a Canadian resident. When the address of the policyowner 2 is different than policyowner 1, we consider that the mailing address corresponds to that of the policyowner 1.

Policyowner 1 (to be completed if change of address)

First and last names _____

Address (civic number, street) _____

City _____ Province _____

Postal code _____

Telephone _____

Policyowner 2 (to be completed if change of address)

Same address as Policyowner 1

First and last names _____

Address (civic number, street) _____

City _____ Province _____

Postal code _____

Telephone _____

B – Other individual insurance in force

If you need more space, continue in Section F.

1. Do you have existing individual insurance? **Insured 1:** NO YES → If yes, please provide the information below.
Insured 2: NO YES → If yes, please provide the information below.

Insured no. or policyowner	Company name	Amount	Type (Life, Disability, Critical Illness)	Year	Purpose of insurance	
					Personal	Business
					<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>

2. Do you have any other applications that are pending or that have been submitted to other companies in the last six (6) months?
 If yes, indicate name of company, the total amount of insurance that will be put into force and the type of insurance (life, critical illness or disability).

Insured 1		Insured 2	
Yes	No	Yes	No
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3. Have you ever had an application or reinstatement for life, disability or critical illness insurance declined, rated, modified or postponed?
 If yes, indicate date and reasons.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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4. If insurance for children:

- a) indicate the total amount of life insurance in force on the parents of the child. \$ _____
 b) please specify if there are other children and if so, indicate the amount of insurance in force on each of them. \$ _____

C – Purpose of insurance

C1 – Personal insurance

- Income / Loan protection Estate conservation Charitable donations

C2 – Business insurance

1. Type of business

- Sole proprietorship Partnership Corporation Other (specify) _____

2. Purpose of insurance

- Buy / sell agreement Key person protection Collateral loan (specify the amount: \$ _____) Estate planning Other (specify at no. 7)

3. Financial information covering the last two (2) years:

Year:	<input type="text" value="Y"/>	<input type="text" value="Y"/>	<input type="text" value="Y"/>	<input type="text" value="Y"/>	Year:	<input type="text" value="Y"/>	<input type="text" value="Y"/>	<input type="text" value="Y"/>	<input type="text" value="Y"/>
Assets:	\$	_____			Assets:	\$	_____		
Liabilities:	\$	_____			Liabilities:	\$	_____		
Net profit:	\$	_____			Net profit:	\$	_____		
Shareholders' assets:	\$	_____			Shareholders' assets:	\$	_____		
Market value:	\$	_____			Market value:	\$	_____		

4. Please complete the following table for each shareholder

Indicate the name, title, percentage of shares as well as the amount of insurance in force and pending for each shareholder in the organization.

Name	Title	% of shares	Insurance in force (business)	Insurance pending (business)
			\$	\$
			\$	\$
			\$	\$
			\$	\$

5. How long has the business been in operation? _____

6. If the associates are not insured for the same amount, please explain the reasons below.

7. Remarks

D – Personal history This section must always be completed for each insured.

- IF THE PARAMEDICAL OR MEDICAL EXAM IS A REQUIREMENT ACCORDING TO THE AGE AND THE AMOUNT, DO NOT COMPLETE SECTION D.

Provide the details of all "Yes" answers here and if you need more space, continue in Section F.	Insured 1		Insured 2	
	Yes	No	Yes	No
1. a) In the last two (2) years, have you participated in activities such as motor vehicle racing, scuba diving, parachuting, ultralight flying, hang gliding, mountaineering or mountain climbing, bungee jumping, out of bounds skiing (heliski, catski, etc.) or any other hazardous sports? If yes, specify activity. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Do you intend to practice any of these activities in the next two (2) years? If yes, specify activity. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. a) In the last three (3) years, have you flown in an aircraft as a pilot, student pilot or crew member? If yes, specify. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Do you intend to practice aviation as a pilot, student pilot or crew member? If yes, specify. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. a) In the last three (3) years, have you been convicted of two (2) or more driving offences and/or had your driver's licence suspended? If yes, provide dates and details. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) In the last ten (10) years, have you been charged with or convicted of impaired driving, hazardous driving or have you refused to take a breathalyzer test and/or had your licence suspended for any of these reasons? If yes, provide dates and relevant details. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

D – Personal history (continued) This section must always be completed for each insured.

Provide the details of all "Yes" answers here, and if you need more space, continue in Section F.	Insured 1		Insured 2																									
	Yes	No	Yes	No																								
4. a) Do you consume alcohol? If yes, specify type and number of drinks consumed on a weekly basis (1 drink = 1 glass of wine [5 ounces] or 1 beer [12 ounces] or 1.5 ounces of spirits). _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																								
b) Has your alcohol consumption been greater in the past? If yes, specify type, number of drinks consumed on a weekly basis and date of change in habits (1 drink = 1 glass of wine [5 ounces] or 1 beer [12 ounces] or 1.5 ounces of spirits). _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																								
If you answered "YES" to questions 4 a) or 4 b), please answer question 4 c) below.																												
c) Have you ever received or been advised to undergo treatment for alcohol abuse, or received counselling for this problem? If yes, indicate date, treatment, result and complete the Alcohol Use questionnaire. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																								
5. a) Do you use or have ever used drugs such as cannabis (marijuana, haschich, etc.) LSD, cocaine, heroin, amphetamines (speed), anabolic steroids or other narcotics? If yes, provide the information below and answer question 6 b) below:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																								
<table border="1"> <thead> <tr> <th>Insured's name</th> <th>Type</th> <th>Quantity</th> <th>Frequency of use</th> <th colspan="2">Dates of use</th> </tr> </thead> <tbody> <tr> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>from _____</td> <td>to _____</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>from _____</td> <td>to _____</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>from _____</td> <td>to _____</td> </tr> </tbody> </table>	Insured's name	Type	Quantity	Frequency of use	Dates of use		_____	_____	_____	_____	from _____	to _____	_____	_____	_____	_____	from _____	to _____	_____	_____	_____	_____	from _____	to _____				
Insured's name	Type	Quantity	Frequency of use	Dates of use																								
_____	_____	_____	_____	from _____	to _____																							
_____	_____	_____	_____	from _____	to _____																							
_____	_____	_____	_____	from _____	to _____																							
b) Have you ever received or been advised to undergo treatment for drug abuse, or received counselling for this problem? If yes, indicate date, treatment, result and complete the Drug Usage questionnaire. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																								
6. Have you ever been charged with or convicted of a criminal offence? If yes, provide the date, the circumstances, the charge(s) and the sentence (probation start and end date if applicable). _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																								
7. a) In the last two (2) years, have you travelled or lived outside of Canada or the United States? If yes, indicate where, when and for how long. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																								
b) In the next two (2) years, do you intend to travel or live outside of Canada or the United States? If yes, complete the Foreign Residence and Travel questionnaire.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																								
8. Have you declared bankruptcy in the last three (3) years? If Yes, please provide details below: <input type="checkbox"/> Personal bankruptcy Amount: \$ _____ <input type="checkbox"/> Professional/commercial bankruptcy Amount: \$ _____ Date filed: [Y Y Y Y M M D D] Date of release: [Y Y Y Y M M D D]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																								

E – Medical history

To be completed for each adult, and each child for any product other than Child Rider and Children's Endorsement.

IF THE PARAMEDICAL OR MEDICAL EXAM IS A REQUIREMENT ACCORDING TO THE AGE AND THE AMOUNT, DO NOT COMPLETE SECTION E.

Insured 1

1. a) Height _____ ft m
Weight _____ lb kg
- b) Weight loss in last 12 months? **Loss:** No Yes How much? _____
Reason(s) for weight change: _____
- c) Name and address of family doctor or the clinic holding your medical file _____
- d) Date and reason of last consultation _____
Results _____
- e) Describe the symptoms that motivated this consultation _____
- f) Tests performed _____
Results _____
- g) Future tests or follow-ups recommended _____
- h) Treatment provided and/or medication prescribed _____

Insured 2

1. a) Height _____ ft m
Weight _____ lb kg
- b) Weight loss in last 12 months? **Loss:** No Yes How much? _____
Reason(s) for weight change: _____
- c) Name and address of family doctor or the clinic holding your medical file _____
- d) Date and reason of last consultation _____
Results _____
- e) Describe the symptoms that motivated this consultation _____
- f) Tests performed _____
Results _____
- g) Future tests or follow-ups recommended _____
- h) Treatment provided and/or medication prescribed _____

For every "Yes" answer in question 2, circle the disorder(s) or condition(s) and provide details in Section F. Please specify dates, diagnosis, tests or examinations, consultations, prescribed medication, treatments, results, and name of any attending physicians and medical facilities consulted.

	Insured 1		Insured 2	
	Yes	No	Yes	No
2. Have you ever been treated for, had symptoms or been diagnosed with any of the following disorders or conditions:				
a) Cardiovascular system: chest pain, high blood pressure, elevated cholesterol, heart murmur, heart attack, stroke, angina, palpitations or heart rate disorder, abnormal ECG, pulmonary hypertension, peripheral vascular disease, blood clots, transient ischemic attack (TIA), cerebrovascular accident (CVA), or any other of the heart or circulatory system disorders or any other heart surgery?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Respiratory system: asthma, chronic bronchitis, emphysema, cystic fibrosis, sleep apnea, chronic obstructive pulmonary disease (COPD), tuberculosis, coughing up blood, shortness of breath, chronic and persistent cough or any other respiratory disorders?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Digestive system: ulcers, colitis, bleedings, polyps or any other disorder of the stomach, esophagus, pancreas, liver, such as hepatitis (including hepatitis carrier) or cirrhosis, or intestines, such as chronic diarrhea, ulcerative colitis, Crohn's disease or intestinal hemorrhaging?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Genitourinary system: sugar, protein, blood or pus in urine, stones or other disorders of the kidneys, such as renal failure, nephritis, disorder of the urinary tract, bladder, prostate or reproductive organs, sexually transmitted disease?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Breast disorder: mass, lump, cyst, other physical changes or abnormal biopsy or mammogram findings?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

E – Medical history (continued)

To be completed for each adult, and each child for any product other than Child Rider and Children’s Endorsement.

For every “Yes” answer in question 2, circle the disorder(s) or condition(s) and provide details in Section F. Please specify dates, diagnosis, tests or examinations, consultations, prescribed medication, treatments, results, and name of any attending physicians and medical facilities consulted.	Insured 1		Insured 2	
	Yes	No	Yes	No
f) Neurological system: loss of consciousness or balance, dizziness, migraine, convulsions, epilepsy, numbness, optic neuritis, multiple sclerosis, Huntington’s chorea, amyotrophic lateral sclerosis (ALS), cerebral palsy, weakness of extremities, loss of sensation, memory loss, Alzheimer’s disease, Parkinson’s disease, motor neuron disease, paralysis, degenerative disease or any other disorder affecting the brain or spinal cord?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) ENT system: eyes, ears, nose, mouth or throat disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) Endocrine and lymphatic system: diabetes, elevated glycemia, thyroid disorder, pituitary gland disorder, enlarged glands, unexplained infection or any form of endocrine or glandular disorder, malignant disease or any lymphatic gland disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i) Immune system: acquired immune deficiency syndrome (AIDS), AIDS-related complex (ARC), HIV positive or any other disorder of the immune system, test indicating the presence of the AIDS virus or antibodies to the AIDS virus?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j) Psychological disorder: depression, anxiety, adjustment disorder, panic disorder, burn-out, bipolar disorder, chronic fatigue, insomnia, suicide attempts, suicidal thoughts, eating disorder, attention deficit with hyperactivity (ADHD), schizophrenia, intellectual deficiency, autism spectrum disorder or any other mental health disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k) Other disorders: skin disorder, blood disorder, such as anemia and coagulation disorder or any other disease or physical disorder not mentioned above?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l) Cancer or tumor: cancer, leukemia, tumor, cyst, nodule, polyp, mole, mass or growth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m) Musculoskeletal disorder: back and neck pain or disorder, arthrosis, herniated disc, sprain, tendinitis, bursitis, chronic pain, fibromyalgia, muscular dystrophy, arthritis, amputation or any other disorder affecting bones, muscles, ligaments or joints, such as shoulders, elbows, wrists, hands, hips, knees, ankles or feet? Provide details of the last five (5) years only.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you taking any medication at the moment (other than those mentioned above)? If yes, indicate name, dosage and date at which the treatment began and reason for which it was prescribed. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Are you aware of any symptoms, signs or discomfort for which you have not yet consulted a physician or received treatment? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you been advised to undergo medical treatment, be hospitalized, undergo an operation or have any tests done, which have not yet been completed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. In the last five (5) years, have you been a patient at a hospital, clinic or any other medical facility? If yes, indicate name, dates, reasons and results. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. In the last five (5) years, have you undergone an x-ray, electrocardiogram (rest or stress) or lab tests, biopsy, magnetic resonance imaging or any other diagnostic test? If yes, indicate dates, reasons and results. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. In the last five (5) years, have you been absent from work or had to stop your regular duties, received disability benefits or any other type of benefits as a result of an accident or illness? If yes, provide date, reason and duration. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Do you have a mental or physical disorder that limits your daily activities?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. In the last five (5) years, have you consulted a chiropractor, physiotherapist, psychologist, audiologist, occupational therapist, osteopath, podiatrist, acupuncturist or any other healthcare professional? If yes, provide the information below:				

Healthcare professional	Reason/diagnosis	Date of first treatment	Date of last treatment	Number of treatment per year	Date of last symptoms

E – Medical history (continued)

To be completed for each adult, and each child for any product other than Child Rider and Children’s Endorsement.

Provide the details of all “Yes” answers here, and if you need more space, continue in Section F.	Insured 1		Insured 2	
	Yes	No	Yes	No

11. For women only:

a) Are you presently pregnant? If yes, indicate the number of weeks you are pregnant, your weight before the pregnancy.

b) Do you have or ever had any pregnancy complications (caesarean section, preeclampsia, ectopic pregnancy, other)?
If yes, provide details:

12. Have any members of your family, including father, mother, brother or sister had any of the following illnesses: heart disease, transient ischemic attack (TIA), cerebrovascular accident (CVA), primary pulmonary hypertension, cancer (provide type), diabetes, kidney disease, mental or neurological illness, alcoholism, Huntington’s chorea, amyotrophic lateral sclerosis (ALS), motor neuron disease, multiple sclerosis, Alzheimer’s disease, muscular dystrophy, Parkinson’s disease or any other hereditary disorder?
If yes, please provide the information below:

Insured’s name	Relationship	Illness	Age at onset	Current age	Age at death	Cause of death

13. In the last 5 years, have you used tobacco in any form, including cigarettes, cigarillos (small cigars), cigars, pipe, chewing tobacco or snuff, shisha, betel nuts, Nicorette chewing gum, electronic cigarette or any other tobacco-derivative or nicotine-containing product?
If YES, provide the information below.

Insured’s name	Type	Daily quantity	Date of last use			
			Y	Y	Y	D
			Y	Y	Y	D
			Y	Y	Y	D
			Y	Y	Y	D
			Y	Y	Y	D
			Y	Y	Y	D

H – Disability Rider (Term Plus and Loan Insurance only)

- The monthly indemnity amount requested must be determined following a needs analysis and based on eligible loans and monthly payments. The benefit payable in the event of a total disability claim may differ from the amount requested, as mentioned in Section J (article 5).
- Certain occupations are not insurable. Please refer to the *List of non-insurable occupations* in the library of the illustration software. Note that a spouse on parental leave must have a regular occupation insurable according to our criteria to be eligible for a maximum amount of \$1,000.

	Insured 1		Insured 2	
1. Eligibility				
a) Are you a stay-at-home spouse? If YES, maximum amount of up to \$1,000 and duration of 2 years. Note: eligible only if the spouse is covered under the present policy.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
b) Are you a spouse on parental leave? If YES, maximum amount of up to \$1,000 and duration of 2 years.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
c) Do you currently work at least 21 hours per week? If NO, not eligible for disability rider.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
d) Have you worked 8 months or more during the last 12 months at a rate of at least 21 hours per week? If NO, not eligible for disability rider.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Home-based work (or from the home(s) of your clients) What percentage of your time do you work from home (or from the home(s) of your clients)?	_____ %		_____ %	
3. Insurance need (based on needs analysis)	\$ _____ / month		\$ _____ / month	
4. Amount requested (min. \$300, max. 1.5% of the life insurance amount requested without exceeding \$3,500)	\$ _____ / month		\$ _____ / month	
5. Duration	<input type="checkbox"/> 2 years <input type="checkbox"/> 5 years <input type="checkbox"/> Up to age 65		<input type="checkbox"/> 2 years <input type="checkbox"/> 5 years <input type="checkbox"/> Up to age 65	
6. a) Are the loans for which the disability insurance amount is requested already covered by another disability insurance policy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
b) Are they covered by a creditor's group disability insurance offered by a bank, credit union or other lender?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
c) If YES, will this insurance be replaced?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No

I – Declaration of Tax Residence of policyowner(s) (self-certification)

(applicable for whole life and universal life insurance)

The insured(s) and the policyowner(s) must be tax residents of Canada in order for an insurance policy to be issued. The information provided on the Declaration of Tax Residence section must be correct and complete. The policyowner(s) must provide SSQ, Life Insurance Company Inc. with a new tax residence declaration within 30 days of any change in circumstances that causes the information on this form to be incomplete or inaccurate (for example, changing a bank account for one in a financial institution in a country other than Canada or the United States, changing an address for an address in a country other than Canada or the United States, etc.).

The policyowner is a corporation or other type of entity

For **whole life insurance** the Declaration of Tax Residence must be completed on the form *Declaration of Tax Residence (Self-Certification) – Entity* (FRA1748A). For **universal life insurance** the Declaration of Tax Residence must be completed on the form *Declaration of Tax Residence (Self-Certification) – Entity* (FRA1748A).

Policyowner 1 (individual)	Policyowner 2 (individual)
Check (✓) all options that apply to you: <input type="checkbox"/> I am a tax resident of Canada <input type="checkbox"/> I am a tax resident of a jurisdiction other than Canada or the United States ➔ If you check this box, the form <i>Declaration of Tax Residence (Self-Certification) – Individual</i> (FRA1737A) is required. <input type="checkbox"/> I am a tax resident of the United States ➔ If you check this box, the form <i>Declaration of Tax Residence (Self-Certification) – Individual</i> (FRA1737A) is required.	Check (✓) all options that apply to you: <input type="checkbox"/> I am a tax resident of Canada <input type="checkbox"/> I am a tax resident of a jurisdiction other than Canada or the United States ➔ If you check this box, the form <i>Declaration of Tax Residence (Self-Certification) – Individual</i> (FRA1737A) is required. <input type="checkbox"/> I am a tax resident of the United States ➔ If you check this box, the form <i>Declaration of Tax Residence (Self-Certification) – Individual</i> (FRA1737A) is required.

L – Payment of premiums

L1 – General information

Total premium amount for this policy reinstatement request: \$ _____

Method of payment

If there are more than six (6) outstanding monthly premiums, the only acceptable method of payment is by cheque (payable to SSQ, Life Insurance Company Inc.).

Enclosed cheque for the amount of \$ _____ Date of cheque | Y | Y | Y | Y | M | M | D | D |

Cashed on reception of this reinstatement request. The reinstatement becomes effective on the date the request is accepted by SSQ, Life Insurance Company Inc.

Pre-authorized debit drawn from the same bank account associated with the policy number mentioned in section A of this form

Pre-authorized debit drawn from a new bank account (complete Section L2 and attach a cheque specimen)

L2 – Pre-authorized debit agreement

1. I hereby authorize SSQ, Life Insurance Company Inc. to debit my account as per my instructions and/or as detailed in the contract of insurance, for monthly recurring payments and/or one time payments from time to time, in payment of all charges, including any applicable financing charges and taxes, arising from the contract of insurance.
2. The amount of the pre-authorized debit may be increased or decreased at a later date as a result of endorsements, cancellation, exclusions or renewal of the contract of insurance. I agree that, for the purpose of this Agreement, all pre-authorized debits from my account will be treated as variable amount pre-authorized debits. I understand that the same method of payment will apply upon renewal of the contract of insurance, if applicable, unless I notify SSQ, Life Insurance Company Inc. before the renewal date of the contract of insurance.
3. I understand that a financing charge may be applicable and spread over the instalments.
4. If a pre-authorized payment is returned due to insufficient funds (NSF), SSQ, Life Insurance Company Inc. is authorized to re-submit the payment. Any charges incurred as a result of NSF may be added to the subsequent pre-authorized payment.
5. I agree to inform SSQ, Life Insurance Company Inc., by way of a letter, of any change in the account information provided in this Agreement at least ten (10) business days prior to the next debit to my account.
6. I agree to the debiting of my account each month on the day selected in this *Policy Reinstatement* form or the next business day.
7. I agree that, for the purpose of this Agreement, all pre-authorized debits from my account will be treated as Personal.
8. **I agree and understand that SSQ, Life Insurance Company Inc. will not notify me before each withdrawal.**

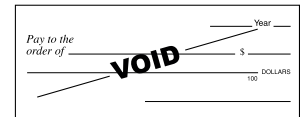
9. In the event that I instruct SSQ, Life Insurance Company Inc. to change the amount of the pre-authorized debit, I waive the right to receive the required notice.
10. I may cancel this authorization for pre-authorized debits at any time, subject to providing SSQ, Life Insurance Company Inc. with thirty (30) days notice in writing. I may contact my financial institution about my rights regarding cancellation, or visit www.cdnpay.ca for a sample cancellation form.
11. I understand that SSQ, Life Insurance Company Inc. reserves the right to terminate this Agreement upon fifteen (15) days notice in writing.
12. Any cancellation of this Agreement will not terminate or otherwise have any bearing on any Agreement that exists with SSQ, Life Insurance Company Inc. whatsoever with respect to any contract of insurance, so long as payment is provided by an alternate method accepted by SSQ, Life Insurance Company Inc.
13. I have certain recourse rights if any debit does not comply with this Agreement. For example, I have the right to receive reimbursement for any debit that is not authorized or is not consistent with this Agreement. To obtain more information on my recourse rights, I may contact my financial institution or visit www.cdnpay.ca.

SSQ, Life Insurance Company Inc.

Premium Accounting

1225 Saint-Charles Street West, Suite 200, Longueuil, Quebec J4K 0B9

Please attach a specimen cheque, on which you have written "VOID", for the account to be debited.



Name of Financial Institution

Address, City, Province and Postal Code of the Branch

Branch

Financial Institution Number

Account Number

Authorization

Is the account joint? Yes No

For a joint account, all account holders must sign if more than one signature is required on cheques issued from the account.

Name of Account Holder or Authorized Person
(in capital letters)

X

Signature

| Y | Y | Y | Y | M | M | D | D |

Date

Name of Account Holder or Authorized Person
(in capital letters)

X

Signature

| Y | Y | Y | Y | M | M | D | D |

Date

M – Signatures

The undersigned:

1. Agree that an additional questionnaire on lifestyle and medical history may be completed during the meeting with the financial security advisor/representative, during a personal meeting or RECORDED telephone conversation with a paramedical company or another authorized person representing or acting for SSQ, Life Insurance Company Inc. The undersigned agree that the additional questionnaire shall be deemed to form part of this *Policy Reinstatement* form and that the information it contains shall be used to draw up a contract with SSQ, Life Insurance Company Inc. The undersigned further agree to review such information upon receipt of the contract and to inform SSQ, Life Insurance Company Inc. forthwith if it contains any information that is false, inaccurate or incomplete.
2. Agree that all information that they divulged during a RECORDED telephone interview to a paramedical company or another authorized person representing or acting for SSQ, Life Insurance Company Inc., including but not limited to, their medical history and state of health, is deemed to form part of this *Policy Reinstatement* form and that this information shall be used to draw up a contract with SSQ, Life Insurance Company Inc. The undersigned agree that any recording, transcription or other notation of such information by SSQ, Life Insurance Company Inc. or on behalf of SSQ, Life Insurance Company Inc. shall be considered to be accurate, complete and binding as if given in writing to you.
3. Agree that, if the information recorded is inaccurate or incomplete (including, without limitation, the information provided to justify the rates applied for non-smokers with respect to an insured under the terms of the requested contract), the contract shall be void with respect to such insured.
4. Authorize any healthcare professional, hospital or private or public health or social services facility, insurance company, reinsurer or other institution or person holding any files or information about them or their health to release such files or information to SSQ, Life Insurance Company Inc. or its reinsurers, and such information shall be treated as confidential and confined in the file mentioned in the *Notice regarding personal files and personal information* which they have read.
5. Agree that, under the Term Plus and Loan Insurance products, the benefit payable in the event of a total disability shall be based on the total amount of eligible monthly payments for all eligible loans in effect at the time of total disability, regardless of the monthly amount that is underwritten in the present *Policy Reinstatement* form. The benefit payable shall not exceed the monthly amount that is underwritten in the present *Policy Reinstatement* form, subject to the terms of the contract. Should there be no eligible monthly payment in effect at the time of total disability, the undersigned agree that the liability of SSQ, Life Insurance Company Inc. shall be limited to the refund of premiums received since the loan or loans were discharged, on the understanding that this refund shall not exceed a period of eighteen (18) months prior to the date the total disability benefit was requested.
6. Authorize SSQ, Life Insurance Company Inc. and its reinsurers, for pricing, underwriting, studies, research and development, regulatory and contractual compliance, the offering of insurance and financial services, and for fraud, error and misrepresentation prevention and detection purposes to hold, collect from, exchange and use with any individuals or corporate bodies holding any personal information about them such personal information as is needed in accordance with the object of the file as aforesaid and only such information, which individuals and corporate bodies shall include any other insurance company, medical practitioner or medical facility, the MIB, LLC, any investigative agency and any individual or corporate body likely to be holding any such personal information about them, to disclose to the aforesaid individuals and corporate bodies only such personal information as is necessary, and to request an investigative report about them. The undersigned also authorize SSQ, Life Insurance Company Inc., and its reinsurers, to make a brief report of their personal information to MIB, LLC. This authorization shall be valid for the period required to achieve the purposes for which it was requested. The undersigned have read the *Notice to proposed insured(s) and policyowner(s)* regarding the MIB, LLC and regarding personal files and personal information and understand that the information shall be treated as confidential and confined in the insured's file as mentioned in the latter notice.
7. Authorize SSQ, Life Insurance Company Inc. and its reinsurers for pricing, underwriting, studies, research and development, regulatory and contractual compliance, the offering of insurance and financial services, and for fraud, error and misrepresentation prevention and detection purposes to have access to and use any relevant information held by any credit rating agency. This authorization remains valid for the length of time needed to achieve such purposes.
8. Declare that the information provided on the Declaration of Tax Residence section is correct and complete and agree to provide SSQ, Life Insurance Company Inc. with a new tax residence declaration within 30 days of any change in circumstances that causes the information on this form to be incomplete or inaccurate.
9. Declare that the information provided on this form with respect to universal life insurance (if applicable) concerning their contact information, identification information, occupation (including field of activity) and the purpose of insurance, is accurate, complete and has been correctly indicated, and they agree to promptly notify SSQ, Life Insurance Company Inc. or their financial security advisor/representative of any change in this information. In such a case, the financial security advisor/representative will forward the updated information to SSQ, Life Insurance Company Inc. without delay.
10. Declare that the aforesaid statements are true and complete, have been correctly recorded and form part of the *Policy Reinstatement* form, with SSQ, Life Insurance Company Inc. This *Policy Reinstatement* form shall be deemed to form part of the insurance contract between the policyowner(s) and SSQ, Life Insurance Company Inc. Any misrepresentation or concealment by the proposed insureds regarding circumstances that are known to the proposed insured and likely to have a material influence on an insurer with respect to setting of premium, the appraisal of risk or the decision to cover it, shall cause the contract, at the insurer's request, to become void even with respect to any losses not connected with the risks so misrepresented or concealed.
11. Declare having received the *Notice to proposed insured(s) and policyowner(s)* and agree to accept its terms.

Signed at (city and province) this _____ day of _____ of year _____
Date

X

Signature of insured 1

X

Signature of the father, mother or legal guardian of the minor child (children's insurance)

X

Signature of policyowner 1 – only necessary if not an insured

X

Signature of insured 2

X

Signature of policyowner 2 – only necessary if not an insured

If the policyowner is a company or other type of entity:

Name and Title of Authorized Signatory

Name and Title of Authorized Signatory

X

Signature

X

Signature

N – Financial security advisor’s / representative’s report

N1 – Information about financial security advisor / representative

The following information is necessary for this form to be processed and for commissions to be paid.

Name of service advisor (in capital letters)

Agency

Code of financial security advisor / representative

Share % (multiples of 5%)

Telephone number

Name of other advisor sharing commission (if applicable) (in capital letters)

Agency

Code of financial security advisor / representative

Share % (multiples of 5%)

Telephone number

Name of other advisor sharing commission (if applicable) (in capital letters)

Agency

Code of financial security advisor / representative

Share % (multiples of 5%)

Telephone number

N2 – Signature of financial security advisor / representative

I confirm that I have provided an “Advisor Disclosure Statement” to the policyowner(s) disclosing the following:

- the name of the company or companies I represent at this moment;
- that I will receive compensation such as commissions for the sale of life and critical illness insurance company products;
- that I may receive additional compensation in the form of bonuses, conference programs or other incentives; and
- that I have disclosed any conflicts of interest that I may have with respect to this transaction.

I declare that I have a valid licence for the territory where this *Policy Reinstatement* form has been signed.

I hereby declare that all information in this *Policy Reinstatement* form is true and complete to the best of my knowledge.

Identity verification of the policyowner(s)

(applicable for universal life insurance)

In accordance with the *Proceeds of Crime (Money Laundering) and Terrorist Financing Act* and its regulations, I have ascertained in their presence the identity of the person(s) who signed this *Policy Reinstatement* form as policyowner(s) by examining all original documents supplied and by meeting with the policyowner(s) to complete this form.

Third party determination

(applicable for universal life insurance)

In accordance with the *Proceeds of Crime (Money Laundering) and Terrorist Financing Act* and its regulations, I have taken reasonable measures to determine if the policyowner(s) is(are) acting on behalf of a third party.

Ongoing monitoring of business relationships

(applicable for universal life insurance)

When the person(s) who has(have) signed this form as policyowner(s) notifies (notify) me of an update to their contact information, identification information, occupation (including field of activity) or the purpose of insurance, I agree to inform SSQ, Life Insurance Company Inc. without delay.

Name of financial security advisor / representative (in capital letters)

Code of financial security advisor / representative

X

Signature of financial security advisor / representative (in capital letters)

Date

Comments and details of financial security advisor / representative

This notice must always be given to the policyowner.

Notice to proposed insured(s) and policyowner(s)

Notice regarding the MIB, LLC

Certain information must be collected when an insurer receives an application for insurance, and this information must be as complete as possible. The information collected may be of a medical or personal nature or regard your solvency.

To help ensure fair underwriting for all insureds, most insurance companies, including SSQ, Life Insurance Company Inc. (SSQ), work with an organization called the MIB, LLC (MIB).

Information regarding your insurability will be treated as confidential. SSQ or its reinsurers may, however, make a brief report thereon to MIB, LLC, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB by emailing Canadadisclosure@mib.com or calling 866-692-6901. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400 Braintree, MA 02184- 8734. Your information may be transmitted and stored outside of Canada and governed by the laws of foreign countries or states.

SSQ or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

Notice regarding the investigative consumer report

For the policy reinstatement requests to be processed, all insurance companies, including SSQ, Life Insurance Company Inc., may ask for a personal investigative consumer report in order to obtain information through personal interviews with neighbours, friends, associates and other designated people. The investigative consumer report may concern your reputation, lifestyle and finances. A representative of a consumer reporting agency may visit you or call you.

Notice regarding personal files and personal information

The protection of your personal information is a priority for SSQ, Life Insurance Company Inc. ("SSQ"). Your personal information is protected by high security standards, in accordance with the applicable laws and regulations regarding the protection of personal information.

Consent for the collection, communicating, use and storage of your personal information

SSQ collects, communicates, uses and holds your personal information for pricing, underwriting, studies, research and development, regulatory and contractual compliance, the offering of insurance and financial services, and for fraud, error and misrepresentation prevention and detection purposes, and this, for the length of time needed to achieve such purposes.

SSQ, its affiliated companies and their distribution channels access, share with each other, use and hold your personal information for the same purposes as those mentioned above. Accordingly, their employees, agents and service providers may have access to your personal information, if they require such access to carry out their duties or if such access is required by a contract.

File purpose, storage location and access to your personal information

SSQ collects, communicates, uses and stores your personal information for the purpose of managing your financial services, insurance, savings, annuities, credit and any other related services file.

Your personal information is held at SSQ's offices. It may be transferred and used securely outside of Canada. If so, it is governed by the laws applicable in that country.

If you would like to access your file or make a rectification to it, make your request in writing to the address below.

SSQ, Life Insurance Company Inc.

1225 Saint-Charles Street West, Suite 200
Longueuil, Quebec J4K 0B9

Notice to proposed insured(s) and policyowner(s)

Notice regarding the MIB, LLC

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Information regarding your insurability will be treated as confidential. SSQ or its reinsurers may, however, make a brief report thereon to MIB, LLC, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB by emailing Canadadisclosure@mib.com or calling 866-692-6901. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400 Braintree, MA 02184-8734. Your information may be transmitted and stored outside of Canada and governed by the laws of foreign countries or states.

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Consent for the collection, communicating, use and storage of your personal information

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SSQ, its affiliated companies and their distribution channels access, share with each other, use and hold your personal information for the same purposes as those mentioned above. Accordingly, their employees, agents and service providers may have access to your personal information, if they require such access to carry out their duties or if such access is required by a contract.

File purpose, storage location and access to your personal information

SSQ collects, communicates, uses and stores your personal information for the purpose of managing your financial services, insurance, savings, annuities, credit and any other related services file.

Your personal information is held at SSQ's offices. It may be transferred and used securely outside of Canada. If so, it is governed by the laws applicable in that country.

If you would like to access your file or make a rectification to it, make your request in writing to the address below.

SSQ, Life Insurance Company Inc.

1225 Saint-Charles Street West, Suite 200
Longueuil, Quebec J4K 0B9

Authorization

Policy number _____

I hereby authorize any doctor, hospital, clinic, insurance company, credit rating agency, the MIB, LLC 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 form with other insurers, financial security advisors / representatives, financial institutions or anyone else I have designated, and to make inquiries with them for pricing, underwriting, studies, research and development, regulatory and contractual compliance, the offering of insurance and financial services, and for fraud, error and misrepresentation prevention and detection purposes.

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, LLC.

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.

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

Authorization

Policy number _____

I hereby authorize any doctor, hospital, clinic, insurance company, credit rating agency, the MIB, LLC 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 form with other insurers, financial security advisors / representatives, financial institutions or anyone else I have designated, and to make inquiries with them for pricing, underwriting, studies, research and development, regulatory and contractual compliance, the offering of insurance and financial services, and for fraud, error and misrepresentation prevention and detection purposes.

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, LLC.

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