SSQ Financial Group
Values in the right place

SSQ Evolution
Subsidiary of SSQ Financial Group

CRITICAL ILLNESS BENEFIT CLAIM

Instructions:

1. Please review all instructions before completing both parts of this claim form.
2. SSQ reserves the right to request additional documents after reviewing the information received.
3. Any professional fees charged to complete this form are the responsibility of the insured.

Section A CLAIMANT'S STATEMENT

1. IDENTIFICATION OF THE PARTICIPANT

1.1 Contract No.: _____
Policy No. Certificate No.

1.2 Last name: _____ 1.3 First name: _____

1.4 Home address: _____ Postal code: _____

I hereby certify that the above information is true, accurate and complete.
For the purposes of reviewing my benefit claim, I authorize SSQ, Life Insurance Company Inc. and its legal agents (hereinafter SSQ) to obtain from corporate persons or individuals such as:

- physicians or other health professionals;
- medical or paramedical establishments or clinics;
- the policyholder, the employer, or the former employer;
- any other insurance or reinsurance companies;
- any public or parapublic organizations body, such as QPP or CPP, CSST, SAAQ, CARRA, EI;
- any other person or institution,
  personal information on myself, namely medical information.

I hereby authorize the said corporate persons or individuals to disclose to SSQ the requested information and I release them of their liability to confidentiality.
Copies of this document shall have the same effect as the original.

_____ Y Y Y Y M M D D _____
At Date Signature of patient

Section B EMPLOYER'S STATEMENT

2. INFORMATION ABOUT THE PARTICIPANT

2.1 Last name: _____ 2.2 First name: _____

2.3 Occupation of insured: Y Y Y Y M M D D 2.4 Employment start date: Y Y Y Y M M D D

2.5 Employment status: ☐ Full time ☐ Part time ☐ Other (please specify): _____

2.6 Last day worked: Y Y Y Y M M D D

2.7 If the participant was not actively at work up to the date of the diagnosis or triggering event, specify the reason:
☐ Sick leave ☐ Vacation ☐ Voluntary departure ☐ Layoff ☐ Other (please specify):

2.8 Gross annual regular salary on last day worked: _____

2.9 If different, gross annual regular salary on the date of the diagnosis or triggering event: _____

3. IDENTIFICATION OF THE EMPLOYER'S AUTHORIZED REPRESENTATIVE

3.1 Last name: _____ 3.2 First name: _____

3.3 Job title: _____ 3.4 Telephone No.: _____ Extension: _____

3.5 Name of employer: _____

I hereby certify that the above information is true, accurate and complete.

_____ Y Y Y Y M M D D
Signature of authorized representative Date

Section C ATTENDING PHYSICIAN'S STATEMENT

4. INFORMATION CONCERNING DIAGNOSIS OF A CRITICAL ILLNESS

4.1 Primary diagnosis: _____

4.2 Date diagnosis was confirmed: Y Y Y Y M M D D

4.3

Physician(s) consulted	Specialty	Date(s) of consultation

4.4 Results of tests and examinations confirming the diagnosis (**please attach copies of the results**):

4.5 If the diagnosis pertains to a tumour, please provide the TNM classification: _____

4.6 If the diagnosis pertains to an amputation: a) Date of amputation: Y Y Y Y M M D D

b) Amputation details: _____

4.7 Does the diagnosis pertain to a loss of sight ☐ hearing ☐ ?

Is the loss total and permanent?

Right eye	☐ Yes	☐ No
Left eye	☐ Yes	☐ No
Right ear	☐ Yes	☐ No
Left ear	☐ Yes	☐ No

4.8 If the diagnosis pertains to paralysis, what was the triggering event? _____

Does the diagnosis pertain to a total, permanent and irrecoverable paralysis? ☐ Yes ☐ No

4.9 Other comments:

5. IDENTIFICATION OF THE PHYSICIAN

5.1 Last Name: _____ 5.2 First Name: _____

5.3 Address: _____

_____ Postal Code: _____

5.4 Licence No.: _____ 5.5 ☐ General practitioner ☐ Specialist Specialty: _____

5.6 Date: Y Y Y Y M M D D

5.7 Signature of physician: _____

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CONSENT TO COLLECT, USE AND DISCLOSE PERSONAL INFORMATION
(Critical illness)

I authorize SSQ, Life Insurance Company Inc., its legal agents, services providers and its reinsurers to collect, use, and disclose personal information about me as permitted by law from and to the following persons and organizations:

- any licensed medical practitioner or licensed health professional, hospital, clinic or medically related facility;
- any other insurance company or financial institution, including any reinsurance company;
- any other person or organization with information relevant to my claim; and
- any person or organization that provides information services or insurance services to, or that acts as insurance intermediary for SSQ, Life Insurance Company Inc.;

for the following purposes:
- establishing and maintaining communications with me;
- underwriting group risks on a prudent basis;
- investigating and setting claims;
- detecting and preventing fraud;
- offering and providing products and services to meet my needs;
- compiling insurance statistics; and
- complying with the law.

The personal information collected by SSQ, Life Insurance Company Inc. and its legal agents will be entered into a file whose subject is accident and sickness insurance. The file will be kept at SSQ, Life Insurance Company Inc. Within SSQ, Life Insurance Company Inc., this file will only be accessed by those employees who require access in order to fulfill the purposes listed above. I understand that I may access my personal information contained in this file and correct such information if necessary by directing a written request to:

Disability insurance services
1610, Bellefeuille street, suite 201,
Trois-Rivières, QC G9A 6H7

This consent shall be valid for the length of time necessary for SSQ, Life Insurance Company Inc. to achieve the purposes listed above. I may withdraw this consent at any time by giving SSQ, Life Insurance Company Inc. written notice of withdrawal. I understand that withdrawal of my consent might result in SSQ, Life Insurance Company Inc. being unable to provide me with a product or service.

A copy of this consent shall be considered as effective and valid as the original.

POLICY NO.

DATE OF THE OCCURRENCE | Y , Y , Y , Y | M , M | D , D |	CAUSE (ACCIDENT, ILLNESS, ETC.)
SIGNATURE OF INSURED **X**	DATE OF SIGNATURE | Y , Y , Y , Y | M , M | D , D |
PRINT NAME OF INSURED	TELEPHONE NUMBER
ADDRESS	

Where the claim is for Accidental Death of the Insured Person, this consent must be signed by their authorized representative, and shall apply to both the Insured Person and the authorized representative:

SIGNATURE OF AUTHORIZED REPRESENTATIVE **X**	DATE OF SIGNATURE | Y , Y , Y , Y | M , M | D , D |
PRINT NAME OF AUTHORIZED REPRESENTATIVE	RELATIONSHIP TO THE INSURED

The completed authorization can be returned at the following address:

Disability insurance services
1610, Bellefeuille street, suite 201,
Trois-Rivières, QC G9A 6H7