SSQ Financial Group

AUTHORIZATION

COLLECT, USE AND DISCLOSE PERSONAL INFORMATION

SSQ, Insurance Company Inc.

110, Sheppard Avenue East, Suite 500
Toronto ON M2N 6Y8
Fax: 416-928-0998

800 - 6th Avenue S.W., Suite 650
Calgary AB T2P 3G3
Fax: 403-261-3101

1225 St-Charles Street West, Suite 200
Longueuil QC J4K 0B9
claims.spgroup@ssq.ca

I authorize SSQ Insurance Company Inc. and its authorized representatives to collect, use, and disclose personal information about me and, where applicable, my dependent children 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 Insurance Company Inc.;

For the following purposes:

- establishing and maintaining communications with me;
- underwriting group risks on a prudent basis;
- investigating and settling claims;
- detecting and preventing fraud;
- compiling insurance statistics; and
- complying with the law.

The personal information collected by SSQ Insurance Company Inc. will be entered into a file whose subject is accident and sickness insurance. The file will be kept at SSQ Insurance Company Inc. offices. Within SSQ 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:

Privacy Officer
SSQ Insurance Company Inc.
1225 St-Charles Street West
Suite 200
Longueuil QC J4K 0B9

This consent shall be valid for the length of time necessary for SSQ Insurance Company Inc. to achieve the purposes listed above. I may withdraw this consent at any time by giving SSQ Insurance Company Inc. written notice of withdrawal. I understand that withdrawal of my consent might result in SSQ 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.	CERTIFICATE NO. (if known)
DATE OF THE OCCURENCE 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 the 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 F F
PRINT NAME OF AUTHORIZED REPRESENTATIVE	RELATIONSHIP TO THE INSURED