REQUEST FOR CHANGE

Contract A4999 (RSGMF)

Identification of Participant

Last Name	First Name
Address	Postal Code
E-mail	Telephone No / Certificate No

Indicate date of the event justifying the Request for Change. year / month / day

- ○ Marriage or civile union
- ○ Birth
- ○ Adoption
- ○ Death of the spouse
- ○ Beginning or termination of spouse's insurance
- ○ Separation / Divorce
- ○ Custody of child
- ○ Other : specify _____
- ○ Change of number of chidren un your care (increase or decrease): specify: _____
- ○ Cohabitation > Start date of cohabitation (year / month / day)
  > Was a child born of this union? If yes, child's date of birth (year / month / day)

Health Insurance (compulsory) (Please check only one box according to the desired coverage.)

	Individual	Single-Parent	Family	Exemption*
Health 1	○	○	○	○
Health 2	○	○	○	
Health 3	○	○	○	

* If you are covered under a similar plan, please provide proof that allows the exemption by completing the fields below:
Name of the insurer: _____
Contract holder's name: _____
Contract Number: _____

Dental Care Insurance (optional)

You must choose only one of the following statuses	○ **Individual**	○ **Single-parent**	○ **Family**	○ **Remove this plan**

Short Term Disability Insurance (compulsory)

Coverage	Modification
Benefits applicable after 7 days of disability for a duration of 52 weeks	**Please note:** Any change to the Short Term Disability Insurance option will result in a change to the Long Term Disability Insurance option ○ Option 1: $300 / weekly ○ Option 3: $500 / weekly ○ Option 2: $400 / weekly ○ Option 4: $600 / weekly

Long Term Disability Insurance (optional)

Coverage	Add	Remove
Benefits applicable up to age 65 The option chosen for Short Term Disability Insurance must be the same as for Long Term Disability Insurance Option 1: $1,300 / monthly Option 3: $2,000 / monthly Option 2: $1,650 / monthly Option 4: $2,350 / monthly	☐ I wish to add this coverage	☐ I wish to remove this coverage

Life Insurance (optional)

Benefit	Add	Modification
Participant's Basic Life Insurance and AD&D	○ Option 1: $25,000 ○ Option 2: $50,000	○ Option 1: $25,000 ○ Option 2: $50,000 ○ I wish to terminate this benefit
Participant's Optional Life Insurance (1 to 20 units of $10,000)	**Increase to** _____ units of $10,000 (indicate the total quantity of units desired)	**Decrease to** _____ units of $10,000 (indicate the total quantity of units desired)
Spouse's and Dependent Children's Life Insurance ($5,000 per insured)	☐	☐
Spouse's Optional Life Insurance (1 to 10 units of $10,000)	**Increase to** _____ units of $10,000 (indicate the total quantity of units desired)	**Decrease to** _____ units of $10,000 (indicate the total quantity of units desired)

Beneficiary

I hereby designate as my beneficiary in the event of my death

Estate of the participant ○ **OR** The insurance proceeds will be payable to the following beneficiary(ies) _____

- ○ **Spouse (married or civil union)**
- ○ **Common-law spouse**
- ○ **Sons / Daughters**
- ○ **Brothers / Sisters**
- ○ **Father / Mother**
- ○ **Spouse and sons / daughters**
- ○ **Common-law spouse and sons / daughters**
- ○ **Other:** _____

The beneficiary designation is revocable ○ * may be changed at any time
The beneficiary designation is irrevocable ○ * CANNOT be changed without the irrevocable beneficiary's written consent

*Under Quebec law, when no beneficiary status is specified, the designation of spouse (married or civil union) is irrevocable and the designation of any other beneficiary is revocable

Non-Smoker's Statement

"I, the undersigned, declare that I do not smoke and have not smoked any tobacco products such as cigarettes, cigars, cigarillos or pipes, nor consumed any drugs during the past twelve (12) months. I understand that SSQ may periodically require confirmation of non-smoker status. A failure to provide this information shall result in the insured person's loss of non-smoker status and the associated premium reduction shall cease to apply as to the date of SSQ's request. I also acknowledge that a false or incomplete declaration may result in coverage becoming null and void."

Signature of the Participant **Date** year / month / day

Signature of the Spouse **Date** year / month / day

Signature of the Participant

Signature of the Participant: Date: year / month / day

Please return this form by using one of the following options:

mail:
SSQ Insurance: 2525 Laurier Boulevard, P.O. Box 10500, Stn. Ste-Foy, Quebec City, (QC) G1V 4H6

e-mail: rsgmf@ssq.ca
fax: 1 866 333-7503