SSQ Financial Group
Values in the right place

SSQ Evolution
Subsidiary of SSQ Financial Group

Please fill out and sign all three copies.
A photocopy of this authorization shall have the same value as the original.

POLICY NUMBER

AUTHORIZATION TO COLLECT AND DISCLOSE PERSONAL INFORMATION

For the purposes of administration and case study of my file, I authorize any person or corporation and any public or parapublic organization that has personal information about me (e.g., my state of health, my medical history or my eligibility for benefits), including but not limited to my physician, dentist or other practitioner, a hospital, medical or paramedical clinic, insurance or reinsurance company, medical information bureau, CSST, RRQ, SAAQ, RAMQ and Human Resources Development Canada (EI), to disclose this information to SSQ, Life Insurance Company Inc., its authorized representatives, service providers or reinsurers upon request.

I also authorize SSQ, Life Insurance Company Inc. and its authorized representatives to disclose this information to the above-mentioned third parties and its reinsurers.

NAME OF INSURED PERSON (PLEASE PRINT):	SIGNATURE: X
ADDRESS:	
SIGNATURE OF WITNESS: X	DATE: Y M D

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