POLICY REINSTATEMENT – INDIVIDUAL INSURANCE

SSQ Financial Group

Values in the right place

SSQ 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 _____

Insured 1

First and last names

Occupation and years of service (current employer)

$ _____
Gross annual income

Address (civic number, street)

City | Province

Postal code | Telephone

Insured 2

First and last names

Occupation and years of service (current employer)

$ _____
Gross annual income

Address (civic number, street)

City | Province

Postal code | Telephone

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
					☐	☐
					☐	☐
					☐	☐

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
☐	☐	☐	☐

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.

_____

Insured 1		Insured 2	
Yes	No	Yes	No
☐	☐	☐	☐

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:	Y Y Y Y	Year:	Y Y Y 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.

Provide the details of all "Yes" answers in section F. If questions 2, 3, 5, 6 and 8 have been answered "Yes", the appropriate additional questionnaire must be completed.	Insured 1		Insured 2	
	Yes	No	Yes	No
1. Have you ever been on a leave of absence, received disability or any type of benefits as the result of an accident or injury? If yes, indicate date, reason and duration.	☐	☐	☐	☐
2. In the last two (2) years, have you participated in activities such as car racing, motor boat racing, scuba diving, parachuting, ultralight flying, hang gliding, mountain climbing, bungee jumping or any other hazardous sport, or do you intend do so? If yes, complete the appropriate questionnaire.	☐	☐	☐	☐
3. In the last three (3) years, have you flown in an aircraft as a pilot, student pilot or crew member, or do you intend to do so? If yes, complete the Aviation questionnaire.	☐	☐	☐	☐
4. 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.	☐	☐	☐	☐
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.	☐	☐	☐	☐
5. 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).	☐	☐	☐	☐
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).	☐	☐	☐	☐
If you answered "YES" to questions 5 a) or 5 b), please answer question 5 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.	☐	☐	☐	☐
6. a) Do you use or have you ever used drugs such as marijuana, LSD, cocaine, heroin or other narcotics? **If yes, provide the information below and answer question 6b) below:**	☐	☐	☐	☐

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.	☐	☐	☐	☐
7. 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 (beginning date and end date of probation, as the case may be).	☐	☐	☐	☐
8. 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.	☐	☐	☐	☐
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.	☐	☐	☐	☐
9. Have you declared bankruptcy in the last three (3) years? ☐ Personal bankruptcy ☐ Professional / commercial bankruptcy Amount: $ _____ If yes, provide the date the bankruptcy was filed and the date of release from bankruptcy. Date filed: Y Y Y Y M M D D Date of release: Y Y Y Y M M D D	☐	☐	☐	☐

E – Medical history

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

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 attending physician:
   d) Date, reason and results of most recent consultation:
   e) Description of ailment(s) that led to this consultation:
   f) Special tests performed? Results?
   g) Other recommended tests?
   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 attending physician:
   d) Date, reason and results of most recent consultation:
   e) Description of ailment(s) that led to this consultation:
   f) Special tests performed? Results?
   g) Other recommended tests?
   h) Treatment provided and/or medication prescribed?

For questions 2 to 6, provide the details of all "Yes" answers in section F. Furthermore, for question 2, when a question is answered "Yes", circle disorder(s) or condition(s) and provide details, including dates, diagnosis, tests or examinations, consultations, prescribed medication, treatments, results and name of any attending physicians or hospitals.	**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, angina, palpitations, rheumatic fever, peripheral vascular disease, blood clots, transient ischemic attack, stroke or neurological deficit, or any other disorder of the heart or circulatory system, including CVAs or any other heart surgery?	☐	☐	☐	☐
b) **Respiratory system:** asthma, chronic bronchitis, emphysema, cystic fibrosis, sleep apnea, chronic obstructive pulmonary disease (COPD), spitting blood, shortness of breath, chronic and persistent cough or any other disorder of the respiratory system?	☐	☐	☐	☐
c) **Digestive system:** ulcers, colitis, bleeding, polyps, or any other disorder of the stomach, pancreas or liver such as hepatitis or cirrhosis or intestines such as chronic diarrhea, ulcerative colitis, Crohn's disease or intestinal hemorrhaging?	☐	☐	☐	☐
d) **Genitourinary system:** sugar, albumin, blood or pus in urine, kidney stones or disorder of the kidneys such as renal failure, disorder of the urinary tract, bladder, prostate or reproductive organs such as sexually transmitted diseases?	☐	☐	☐	☐
e) **Neurological system:** loss of consciousness or balance, migraine, convulsions, epilepsy, numbness, multiple sclerosis, Huntington's chorea, amyotrophic lateral sclerosis, weakness of extremities, loss of sensation, memory loss, Alzheimer's disease, Parkinson's disease, motor neuron disease or disorder of the eyes or ears such as dizziness, optic neuritis, paralysis or any other disorder affecting the brain or spinal cord?	☐	☐	☐	☐
f) **Endocrine system:** diabetes, anemia, leukemia, disorder of the thyroid, pituitary gland or breasts, enlarged glands or unexplained infection, skin disorder or any form of endocrine or glandular disorder or malignant disease?	☐	☐	☐	☐
g) **Musculoskeletal system:** lower back pain, disk disease such as herniated disc, rheumatism, or any other disorder of the muscles, bones, ligaments or cartilage such as arthritis, amputation, injury, pain, fibromyalgia or disorders of the neck, spine, back and joints, delayed physical development or muscular dystrophy?	☐	☐	☐	☐
h) **Immune system:** acquired immune deficiency syndrome (AIDS), AIDS-related complex (ARC), HIV-positive result, or any other disorder of the immune system, test indicating the presence of the AIDS virus or antibodies to the AIDS virus?	☐	☐	☐	☐
i) **Nervous system:** depression, anxiety, fatigue, insomnia, attempted suicide, suicidal thoughts, burn-out, eating disorder, ADHD, schizophrenia or any other mental illness or nervous disorder, delayed mental development, autism, cerebral palsy?	☐	☐	☐	☐
j) **Other disorders:** cancer, tumour, cyst, nodule, polyp, gout, Down's syndrome, Behçet's syndrome or any other hereditary, physical or mental disease not mentioned above?	☐	☐	☐	☐

	Insured 1		Insured 2	
	Yes	No	Yes	No
3. Are you taking medication at the moment? If yes, indicate name, dosage and date on which the treatment began. _____	☐	☐	☐	☐
4. Are you aware of any symptoms, signs or ailments for which you have not yet consulted a physician, received treatment or been advised to undergo tests or surgery that has not yet been performed?	☐	☐	☐	☐
5. 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. _____	☐	☐	☐	☐
6. In the last five (5) years, have you undergone an x-ray, electrocardiogram or lab tests, biopsy, magnetic resonance imaging or any other diagnostic test? If yes, indicate dates, reasons and results. _____	☐	☐	☐	☐
7. In the last five (5) years, have you consulted a chiropractor, physiotherapist, psychologist, audiologist, occupational therapist, osteopath or podiatrist? If yes, indicate dates, reasons and results for consultation. _____	☐	☐	☐	☐
8. For women only: are you presently pregnant? If yes, indicate the number of weeks you are pregnant, your weight before the pregnancy and gain since the pregnancy. _____	☐	☐	☐	☐
9. Have any members of your family, including the father, mother (and grandparents if the father or the mother is under age 40), brother or sister, had any of the following illnesses: heart disease, transient ischemic attack or stroke, cancer (specify type), diabetes, kidney disease or mental illness, alcoholism, Huntington's chorea, amyotrophic lateral sclerosis, motor neuron disease, multiple sclerosis, Alzheimer's disease, Parkinson's disease or any other hereditary disease? **If yes, provide the information below:**	☐	☐	☐	☐

Insured's name	Relationship	Condition	Age at onset	Current age	Age at death	Cause of death

10. 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, specify the type, the daily quantity and the date of last use.**	Yes	No	Yes	No
	☐	☐	☐	☐

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

F – Details and additional information

Question No.	Insured’s first name	**Details** Specify the disorder(s) or condition(s) and provide details, including dates, diagnosis, tests or examinations, consultations, prescribed medication, treatments, results, and name of any attending physicians or hospitals.

G – Child Rider / Children's Endorsement

Note regarding life and critical illness insurance for children: children are insured from the age of fifteen (15) days for life insurance and thirty (30) days for critical illness insurance.

First and last names ____ Date of birth (YYYY MM DD) ____ Sex ☐ M ☐ F

Relationship to policyowner(s) ____ Height ____ ☐ FT ☐ M Weight ____ ☐ LB ☐ KG

Name of attending physician and/or hospital ____ Address ____ Date of last consultation (YYYY MM DD) ____

Indicate the reason, the results and the recommended treatments if applicable ____

Insurance in force (life / critical illness) ____ Company name ____ Face amount $ ____ Issue date ____

First and last names ____ Date of birth (YYYY MM DD) ____ Sex ☐ M ☐ F

Relationship to policyowner(s) ____ Height ____ ☐ FT ☐ M Weight ____ ☐ LB ☐ KG

Name of attending physician and/or hospital ____ Address ____ Date of last consultation (YYYY MM DD) ____

Indicate the reason, the results and the recommended treatments if applicable ____

Insurance in force (life / critical illness) ____ Company name ____ Face amount $ ____ Issue date ____

First and last names ____ Date of birth (YYYY MM DD) ____ Sex ☐ M ☐ F

Relationship to policyowner(s) ____ Height ____ ☐ FT ☐ M Weight ____ ☐ LB ☐ KG

Name of attending physician and/or hospital ____ Address ____ Date of last consultation (YYYY MM DD) ____

Indicate the reason, the results and the recommended treatments if applicable ____

Insurance in force (life / critical illness) ____ Company name ____ Face amount $ ____ Issue date ____

	Yes	No	
1. Has any child to be insured:			If yes, give child(ren)'s first name(s) and provide details
a) ever suffered from any congenital malformation or hereditary disease?	☐	☐	
b) ever suffered from any other illness or affliction?	☐	☐	
c) ever had an application for life insurance declined, rated or postponed?	☐	☐	
2. Are all the children to be insured presently in good health and free of any illness or affliction?	☐	☐	If no, give child(ren)'s first name(s) and provide details

If Children's Endorsement is chosen, also complete the "Critical Illness Questionnaire – Child".

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 Term Plus section of the library in 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.	☐ Yes ☐ No	☐ Yes ☐ No
b) Are you a spouse on parental leave? If YES, maximum amount of up to $1,000 and duration of 2 years.	☐ Yes ☐ No	☐ Yes ☐ No
c) Do you currently work at least 21 hours per week? If NO, not eligible for disability rider.	☐ Yes ☐ No	☐ Yes ☐ 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.	☐ Yes ☐ No	☐ Yes ☐ 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	☐ 2 years ☐ 5 years ☐ Up to age 65	☐ 2 years ☐ 5 years ☐ Up to age 65
6. a) Are the loans for which the disability insurance amount is requested already covered by another disability insurance policy?	☐ Yes ☐ No	☐ Yes ☐ No
b) Are they covered by a creditor's group disability insurance offered by a bank, credit union or other lender?	☐ Yes ☐ No	☐ Yes ☐ No
c) If YES, will this insurance be replaced?	☐ Yes ☐ No	☐ Yes ☐ No

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

(applicable to whole life and universal life insurance products)

The information provided on the Declaration of Tax Residence section must be correct and complete. The policyowner(s) must provide SSQ, 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

The Declaration of Tax Residence must be completed on the form V*erification of the existence (identity) of corporations and other entities* (FRA1235A).

Policyowner 1 (individual)	Policyowner 2 (individual)
Check (✓) all options that apply to you:	**Check (✓) all options that apply to you:**
☐ I am a tax resident of Canada	☐ I am a tax resident of Canada
☐ I am a tax resident in a jurisdiction other than Canada or the United States	☐ I am a tax resident in a jurisdiction other than Canada or the United States
→ **If you check this box, the form *Declaration of Tax Residence (Self-Certification) – Individual* (FRA1737A) is mandatory.**	→ **If you check this box, the form *Declaration of Tax Residence (Self-Certification) – Individual* (FRA1737A) is mandatory.**

J – Identity of the policyowner(s)

(applicable to whole life and universal life insurance products)

This section must be completed by the financial security advisor/representative. If he/she is not present, do not complete this section.

The financial security advisor/representative must:

- verify the identity of each policyowner, as required by the *Proceeds of Crime (Money Laundering) and Terrorist Financing Act*;
- review the applicable document indicated below for that person (must be a government issued photo identification document). In Quebec, you are not allowed to request the client's Health Card, but you can accept it only if the client offers it to you. In the provinces of Ontario, Manitoba, Nova Scotia and Prince Edward Island, the use of a Health Card for identification purposes is prohibited;
- indicate, for each policyowner, which of the required documents has been reviewed, its number, its expiration date and jurisdiction. The identifying document must be an unexpired original. If the document is "Other photo identification document admissible by Law", please specify the type of document verified.

Policyowner 1	Policyowner 2
Name of the policyowner (as appearing on the document)	**Name of the policyowner (as appearing on the document)**
Profession/Occupation (provide details)	Profession/Occupation (provide details)
Is the policyowner a canadian citizen or a permanent resident (holds a permanent resident card? ☐ Yes ☐ No	Is the policyowner a canadian citizen or a permanent resident (holds a permanent resident card? ☐ Yes ☐ No
The policyowner must be a canadian resident.	**The policyowner must be a canadian resident.**
☐ Driver's licence ☐ Passport ☐ Citizenship card with photo ☐ Other photo identification document admissible by Law (specify): _____	☐ Driver's licence ☐ Passport ☐ Citizenship card with photo ☐ Other photo identification document admissible by Law (specify): _____
Document number / Juridiction	Document number / Juridiction
Document expiration date (Y Y Y Y M M D D) / SIN*	Document expiration date (Y Y Y Y M M D D) / SIN*

* Social Insurance Number (SIN) required for tax purposes (applicable for whole life and universal life insurance products); not required when the policyowner is a corporation or another type of entity.

K – Third party determination

Is the premium payer different than the policyowner(s)? ☐ Yes ☐ No

Is there a third party to this contract or is there a third party who will have the use of and/or access to the value of the contract? ☐ Yes ☐ No

If YES, provide information on the premium payer and/or the third party below:

Third party Identification (if applicable)

Name of third party / Date of birth of third party (Y Y Y Y M M D D)

Address of third party

Principal business or occupation of the third party / Relationship between the third party and the policyowner(s)

If the third party is a corporation or other type of entity:

Business number / Place of issuance of its certificate of constitution

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 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 Insurance Company Inc.

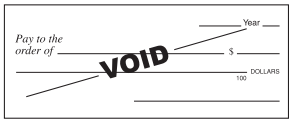
☐ Pre-authorized debit drawn from the same bank account associated with the policy number mentioned in section A of this form
☐ Pre-authorized debit drawn from a new bank account (complete section L2 and attach a cheque specimen)

L2 – Pre-authorized debit agreement

1. I hereby authorize SSQ 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 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 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 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 Insurance Company Inc. will not notify me before each withdrawal.**
9. In the event that I instruct SSQ 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 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 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 Insurance Company Inc. whatsoever with respect to any contract of insurance, so long as payment is provided by an alternate method accepted by SSQ 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 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	Date Y Y Y Y M M D D

Name of Account Holder or Authorized Person (in capital letters)	**X** Signature	Date Y Y Y Y M M D D

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 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 Insurance Company Inc. The undersigned further agree to review such information upon receipt of the contract and to inform SSQ 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 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 Insurance Company Inc. The undersigned agree that any recording, transcription or other notation of such information by SSQ Insurance Company Inc. or on behalf of SSQ 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 health care 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 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 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 Insurance Company Inc. and its reinsurers, for the purposes of underwriting, appraisal of risk, setting of premiums, insurance administration and loss settlement only, to hold, collect from and exchange 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 Inc., any credit rating or 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. 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 Inc. 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, Insurance Company Inc., when required by law, to ascertain my identity by means of a reliable and independent identification product and/or any other method provided by law.
8. Declare that the information provided on the Declaration of Tax Residence section is correct and complete and agree to provide SSQ, 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 aforesaid statements are true and complete, have been correctly recorded and form part of the *Policy Reinstatement* form, with SSQ Insurance Company Inc. This *Policy Reinstatement* form shall be deemed to form part of the insurance contract between the policyowner(s) and SSQ 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.

_____ this _____ day of _____ of year _____

Signed at (city and province) Date

X _____ **X** _____

Signature of insured 1 Signature of insured 2

X _____

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

X _____ **X** _____

Signature of policyowner 1 – only necessary if not an insured Signature of policyowner 2 – only necessary if not an insured

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

_____ **X** _____

Name and Title of Authorized Signatory Signature

_____ **X** _____

Name and Title of Authorized Signatory 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)
(whole life insurance and universal life insurance)

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

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) | Y Y Y Y M M D D
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 Inc.

Information regarding each proposed insured will be treated as confidential and will be confined in the file mentioned in the Notice regarding personal files and personal information. SSQ Insurance Company Inc. or its reinsurers may, however, make a brief report thereon to the MIB Inc., a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members. If you apply to another MIB Inc. member company for life, disability or critical illness insurance coverage, or a claim for benefits is submitted to a member company, the MIB Inc. will, upon request, supply such company with the information in its file. Upon receipt of a request from you, the MIB Inc. will arrange disclosure of any information it may have in your file. If you question the accuracy of information in a file at the MIB Inc., you may contact the MIB Inc. and seek a correction. Here is the address of the MIB Inc.:

MIB Inc., 330 University Avenue, Suite 501, Toronto, Ontario, Canada M5G 1R7, Telephone: 416-597-0590.

SSQ Insurance Company Inc. or its reinsurers may also release information in its files to other life insurance companies to whom you may apply for life, disability or critical illness insurance coverage, or to whom a claim for benefits may be submitted. By signing the authorization clause, the insureds agree to the release of the information to the MIB Inc.

Information for consumers about MIB Inc. 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 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

SSQ Insurance Company Inc. advises the insureds that all information obtained from them or from a third party, as mentioned in this **Policy Reinstatement** form, for the risk assessment, premium calculations and claims is stored in a file referred to as "Life and Health Insurance". Only the employees, representatives or agents of SSQ Insurance Company Inc. and the people authorized by the insured have access to this file when needed to exercise their duties, execute their mandates or as authorized by the insured. This file is maintained at the office of SSQ Insurance Company Inc. The proposed insured is entitled to have access to the personal information in this file and, if applicable, to rectify any inconsistencies. To do so, a written request must be sent to the attention of the Access Officer, SSQ Insurance Company Inc. at 1225 Saint-Charles Street West, Suite 200, Longueuil, Quebec J4K 0B9. By signing the authorization form at the end of this **Policy Reinstatement** form, the insureds agree to the gathering of information which will be confined in the above-mentioned file.

This notice must always be given to the policyowner

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

Notice regarding the MIB Inc.

Information regarding each proposed insured will be treated as confidential and will be confined in the file mentioned in the Notice regarding personal files and personal information. SSQ Insurance Company Inc. or its reinsurers may, however, make a brief report thereon to the MIB Inc., a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members. If you apply to another MIB Inc. member company for life, disability or critical illness insurance coverage, or a claim for benefits is submitted to a member company, the MIB Inc. will, upon request, supply such company with the information in its file. Upon receipt of a request from you, the MIB Inc. will arrange disclosure of any information it may have in your file. If you question the accuracy of information in a file at the MIB Inc., you may contact the MIB Inc. and seek a correction. Here is the address of the MIB Inc.:

MIB Inc., 330 University Avenue, Suite 501, Toronto, Ontario, Canada M5G 1R7, Telephone: 416-597-0590.

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Authorization

Policy number _____

I hereby authorize any doctor, hospital, clinic, insurance company, the MIB Inc. 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 Insurance Company Inc. and to its reinsurers. I also authorize my insurer to exchange any personal information contained in the present **Policy Reinstatement** form with other insurers, financial security advisors / representatives, financial institutions or anyone else I have designated, and to make inquiries with them for the purposes of risk selection, premium calculation or in the event of a claim.

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 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 Insurance Company Inc. may request in order to underwrite my policy reinstatement request. Furthermore, I authorize SSQ Insurance Company Inc. to communicate the results of these tests to its reinsurers, and as required, to my attending physician and the MIB Inc. In addition, I authorize SSQ 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.

Note: please complete this authorization in blue ink.

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

Authorization

Policy number _____

I hereby authorize any doctor, hospital, clinic, insurance company, the MIB Inc. 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 Insurance Company Inc. and to its reinsurers. I also authorize my insurer to exchange any personal information contained in the present **Policy Reinstatement** form with other insurers, financial security advisors / representatives, financial institutions or anyone else I have designated, and to make inquiries with them for the purposes of risk selection, premium calculation or in the event of a claim.

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 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 Insurance Company Inc. may request in order to underwrite my policy reinstatement request. Furthermore, I authorize SSQ Insurance Company Inc. to communicate the results of these tests to its reinsurers, and as required, to my attending physician and the MIB Inc. In addition, I authorize SSQ 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.

Note: please complete this authorization in blue ink.

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