

SECTION 1

CONTRACT NO. _____ GENDER M <input type="checkbox"/> F <input type="checkbox"/>	SOCIAL INSURANCE NUMBER _____ I DECLARE THAT ALL ATTACHED EXPENSES HAVE BEEN INCURRED FOR: MYSELF <input type="checkbox"/> MY SPOUSE <input type="checkbox"/> MY DEPENDENT CHILDREN (INDICATED BELOW) <input type="checkbox"/> If your child is studying full time, complete Section 3 below. <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:70%;"></td> <td colspan="3" style="text-align: center;">DATE OF BIRTH</td> </tr> <tr> <td style="text-align: center;">FIRST NAME</td> <td style="text-align: center;">Y</td> <td style="text-align: center;">M</td> <td style="text-align: center;">D</td> </tr> <tr> <td> </td> <td> </td> <td> </td> <td> </td> </tr> </table>		DATE OF BIRTH			FIRST NAME	Y	M	D				
	DATE OF BIRTH												
FIRST NAME	Y	M	D										
NAME OF PARTICIPANT: _____ ADDRESS: _____ POSTAL CODE: _____ TOWN/CITY: _____ PROVINCE: _____ COVERAGE STATUS: FAMILY <input type="checkbox"/> INDIVIDUAL <input type="checkbox"/> SINGLE-PARENT <input type="checkbox"/> COUPLE <input type="checkbox"/>	IMPORTANT Complete this coupon and attach your receipts. Please send only original copies of receipts or paid invoices. Please keep a copy of all documents sent as receipts will not be returned. Official prescription receipts should be grouped in order by date of purchase. You are invited to file your claims at regular 3-month intervals.												
	ARE THESE EXPENSES COVERED UNDER ANOTHER INSURANCE CONTRACT? NO <input type="checkbox"/> YES <input type="checkbox"/> IF YES, COMPLETE SECTION 2 BELOW. ARE THESE EXPENSES THE RESULT OF A WORK ACCIDENT? NO <input type="checkbox"/> YES <input type="checkbox"/> ARE THESE EXPENSES THE RESULT OF AN AUTOMOBILE ACCIDENT? NO <input type="checkbox"/> YES <input type="checkbox"/> I authorize the organizations or health professionals involved to provide SSQ, Life Insurance Company Inc., with information regarding this claim. DATE _____ TEL.: _____ SIGNATURE _____												

SECTION 2

TO BE COMPLETED IF YOU HAVE SIMILAR HEALTH INSURANCE COVERAGE WITH ANOTHER INSURER		COVERAGE STATUS
	Y M D	FAMILY <input type="checkbox"/>
NAME OF POLICYHOLDER _____	DATE OF BIRTH _____	INDIVIDUAL <input type="checkbox"/>
NAME OF OTHER INSURER _____	CONTRACT NO. _____	SINGLE-PARENT <input type="checkbox"/>
		COUPLE <input type="checkbox"/>

SECTION 3

TO BE COMPLETED FOR AN OVERAGE DEPENDENT IF UNMARRIED AND STUDYING FULL TIME	
I DECLARE THAT MY CHILD _____	BORN ON _____
NAME OF CHILD	Y M D
IS UNMARRIED AND IS ENROLLED AT THE HIGH SCHOOL, COLLEGE OR UNIVERSITY _____	
NAME OF SCHOOL, COLLEGE OR UNIVERSITY	
AS A FULL-TIME STUDENT FOR THE 20 _____ - 20 _____ ACADEMIC YEAR, AND IS FOLLOWING A COURSE OF STUDY IN _____	
DATE _____	SIGNATURE OF PARTICIPANT _____

FPM666A (2006-05)

Effective October 1, 2008, all claims should be submitted to:

CEP 24/7 Benefit Trust
c/o Global Benefits Claims Department
545 Wilson Avenue
Toronto ON M3H 1V2

Policy Number: 32S20

Authorization	
Plan Member/Employee Authorization	
I hereby authorize my employer, group plan administrator, the insurance company or their agents, or any other person or organization to release and exchange any and all information necessary for the purpose of determination of eligibility for benefits and administration of the group benefits plan. I confirm I am authorized to act on behalf of my spouse and/or dependents for such purposes.	
I authorize the use of my Social Insurance Number as my Certificate Number under the group plan and as my identification number in the CEP 24/7 Benefit Trust database and that it is my responsibility to advise my Plan Administrator if I do not wish my Social Insurance Number to be used to identify me under the group plan.	
I declare that the information provided is true, complete and accurate. Any copy of this authorization shall be valid as the original.	
Signature du participant _____	Date mm/jj/aaaa _____

