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beneva FMSQ

Insurance application

Enrolment ☐ Increase ☐ Modification ☐

A group insurance plan underwritten by Beneva Inc. (Beneva Inc.) and administered by Sogemec Assurances financial services firm

Policy 88H00

PRESCRIPTION DRUG, HEALTH AND DENTAL CARE INSURANCE

PERSONAL INFORMATION

Last name ______________________ First name ______________________

Date of birth: Y Y Y Y | M M | D D   Sex at birth: ☐ F ☐ M   Language preference: ☐ English ☐ French   Physician No.: __________   Specialty: __________

Address: ☐ Residence ☐ Office

No. Street Suite or apt. City

Province __________ Postal code ______ Email __________

Telephone: Office: __________ Residence: __________ Cell: __________

Effective date of insurance: Y Y Y Y | M M | D D

COVERAGE CHOICE

All coverage provided by the contract is subject to the provisions concerning limitations, reductions and exclusions.
For Quebec residents only: Legislation provides for a 10-day grace period for cancelling an optional benefit.

PRESCRIPTION DRUG AND HEALTH CARE INSURANCE — The selection is effective for a minimum period of two years.

☐ OPTION 1 – PRESCRIPTION DRUG INSURANCE	☐ OPTION 2 – PRESCRIPTION DRUG AND HEALTH CARE INSURANCE	☐ OPTION 3 – RAMQ PRESCRIPTION DRUG INSURANCE LIST
Deductible: • $200 - Individual and Single-Parent • $400 - Couple and Family Coinsurance: 75% Maximum annual contribution per adult: • The RAMQ maximum amount Coverage: • Drugs that can only be obtained on prescription • Travel and trip cancellation insurance	Deductible: • $200 - Individual and Single-Parent • $400 - Couple and Family Prescription drug coinsurance: 80% Maximum annual contribution per adult: • The RAMQ maximum amount Medical and paramedical expenses coinsurance: 80% of eligible expenses Coverage: • Drugs that can only be obtained on prescription • Travel and trip cancellation insurance • Medical and paramedical expenses	Deductible: • $150 - Individual and Single-Parent • $300 - Couple and Family Coinsurance: 66% Maximum annual contribution per adult: • The RAMQ maximum amount Coverage: • Prescription drugs – RAMQ list

Evidence of insurability may be required. Please consult the *Transfer of a Group Insurance Plan* section.

☐ **DENTAL CARE INSURANCE**
The coverage is optional, but is conditional on selecting Option 2. The selection is effective for a minimum period of three years. Dental care expenses incurred in the first six months of insurance coverage are not reimbursed if enrolment in this benefit is submitted to the insurer 180 days after your eligibility date.

Deductible: $100	Coinsurance: • 100%: Basic and preventive • 80%: Minor restoration • 50%: Major restoration Maximum per calendar year: $1,500 per insured person for all these benefits	Coinsurance: 50% - Orthodontic care Lifetime maximum: $1,500 per insured

Please check the selected or modified coverage: ☐ ndividual ☐ Single-Parent ☐ Couple ☐ Family

If this involves a change to coverage: Y Y Y Y | M M | D D

Event justifying the modification (marriage, birth, divorce, etc.): ______________ Date of the event: Y Y Y Y | M M | D D

INFORMATION ABOUT DEPENDENTS

Complete if you selected Single-Parent, Couple or Family coverage status.

Spouse's name at birth: ______________ First name: ______________

Sex at birth: ☐ F ☐ M Date of birth: Y Y Y Y | M M | D D

Child's full name:	Sex at birth	Date of birth	Does the child have a disability?	For children age 18 or over, are they full-time students?	Name of educational institution
	☐ F ☐ M	Y Y Y Y M M D D	☐ Yes ☐ No	☐ Yes ☐ No	
	☐ F ☐ M	Y Y Y Y M M D D	☐ Yes ☐ No	☐ Yes ☐ No	
	☐ F ☐ M	Y Y Y Y M M D D	☐ Yes ☐ No	☐ Yes ☐ No	
	☐ F ☐ M	Y Y Y Y M M D D	☐ Yes ☐ No	☐ Yes ☐ No	
	☐ F ☐ M	Y Y Y Y M M D D	☐ Yes ☐ No	☐ Yes ☐ No	
	☐ F ☐ M	Y Y Y Y M M D D	☐ Yes ☐ No	☐ Yes ☐ No	

PAYMENT METHOD – Please select one option only: 1 or 2

☐ **OPTION 1: MONTHLY PAYMENTS DEBITED FROM YOUR ACCOUNT (PAD)**

The payments will be debited monthly from the account indicated below.

Types of services: ☐ Personal ☐ Business **Please attach a VOID cheque.**

Name of account holder	**Name of financial institution**	**Bank account No.**
Full address of the financial institution		**Transit number**

Type of account: ☐ Personal chequing account ☐ Savings-chequing account ☐ Direct deposit account ☐ Other

Joint accounts: Is this a joint account requiring only one signature? ☐ Yes ☐ No

If more than one signature is required to authorize debits from this account, both account holders must sign this authorization.

I/We authorize Sogemec Assurances Inc. to debit an amount of $_____ from my/our bank account in payment of the monthly insurance premiums owing on or near the signature date of this authorization or the following business day. The amount debited from my/our account may vary in accordance with the provisions of the insurance contract or as required for managing the contract. I/we waive the right to receive 10-day notice of the amount and date of each debit from my/our account. If the bank or financial institution does not honour a monthly debit on the scheduled date, Sogemec Assurances Inc. may make a second attempt in the following 30 days. Sogemec Assurances Inc. reserves the right to require another payment method if the debit is refused. All single or automatic debits from my/our bank account will be treated as personal preauthorized debits as defined in Rule H1, Pre-authorized Debits (PADS) issued by Payments Canada. I/we can cancel this agreement at any time by sending written notice of 10 days to Sogemec Assurances Inc. It is understood that in the event this preauthorized debit agreement is cancelled, the insurance may terminate unless Sogemec Assurances Inc. receives payment in another way.

You can obtain a form for cancelling the agreement by contacting your financial institution or by going to Payments Canada at payments.ca. If you have questions about any debits from your bank account, please contact us at 1 800 361-5303, email us at **information@sogemec.com** or mail a letter to Sogemec Assurances Inc., CP 217, Succ Desjardins, Montréal, Québec, H5B 1G9.

You have certain recourse rights if any debit does not comply with this agreement. You have the right to be reimbursed for any unauthorized debits or those that do not comply with this agreement. To obtain a reimbursement request form or for further information about your recourse rights, please contact your financial institution or visit the Payments Canada site at payments.ca.

Name of the account holder (IN CAPITAL LETTERS)	**Signature of the account holder**
Second signature if this is a joint account	**Date**

☐ **OPTION 2: ANNUAL PAYMENT BY CHEQUE**

Type of services: ☐ Personal ☐ Business

Please attach a cheque made out to Sogemec Assurances Inc.

DECLARATION AND AUTHORIZATION FOR THE COLLECTION AND COMMUNICATION OF PERSONAL INFORMATION

I HEREBY CERTIFY to the best of my knowledge that all the information provided in this form is true and complete. **I CONFIRM** that I am authorized to disclose the information concerning my spouse and my dependent children for establishing their eligibility for any coverage that concerns them. **I CONSENT** to the information provided in this form being disclosed to Sogemec Assurances Inc. and to Beneva Inc., its employees, its agents, its reinsurers and its service providers who are responsible for contract management, investigations, underwriting and processing claims under the FMSQ's group insurance plan. **I ACKNOWLEDGE** that any insurance coverage provided in accordance with this application is subject to the provisions of the policy issued to the FMSQ. **I CONFIRM** that I have read the FMSQ insurance plan informational booklet. **I UNDERSTAND** that a photocopy of this authorization is considered as valid as the original. **I ACKNOWLEDGE** that I have read the notice below concerning the protection of personal information. **I CONFIRM** that I have kept a copy of this duly completed and signed form.

Plan member's signature: _____ Date: Y Y Y Y M M D D Spouse's signature: _____

NOTE: The signatures below are only required if a representative completed this application form.

Representative's signature: _____ Training supervisor's signature (if trainee): _____ Date: _____

PROTECTION OF PERSONAL INFORMATION

Beneva Inc. and Sogemec Assurances Inc. (Sogemec) protect the confidentiality of your personal information. Beneva Inc. and Sogemec respectively store this information in a file for the purpose of allowing you to benefit from the group insurance services they offer. This information is only consulted by Beneva Inc. and Sogemec employees who must do so to perform their duties. Beneva Inc. may compile anonymized information for statistical and informational purposes. You have the right to access your file at Beneva Inc.and Sogemec. You may also have any information corrected if you demonstrate that it is inaccurate, incomplete, ambiguous or unnecessary. To do so, you must send a written request to one of the following addresses:

Beneva Inc.
Personal Information Protection Officer
2525 boul Laurier
CP 10500 succ Sainte-Foy
Québec QC G1V 4H6

Sogemec Assurances Inc.
2 Complexe Desjardins, Tour de l'est 20e étage
CP 217, succ Desjardins
Montréal QC H5B 1G9

Beneva Inc. and Sogemec may use their client lists for offering an insurance product after their group insurance terminates. If you do not wish to receive these offers, you have the right to have your name deleted from this list. To do so, send a written request to the Personal Information Protection Officer at Beneva Inc. or Sogemec.

Please send this form to Sogemec Assurances: **https://sogemec.com/en/client-area/medical-specialist-file-deposit/**