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SSQ insurance

FÉDÉRATION DES MÉDECINS OMNIPRATICIENS DU QUÉBEC

INSURANCE APPLICATION

Enrolment ☐ Increase ☐ Modification ☐

A group insurance plan underwritten by SSQ, Life Insurance Company (SSQ Insurance) and administered by Sogemec ASSURANCES financial services firm

Policy 13K00

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: ☐ F ☐ M Language preference: ☐ English ☐ French

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

Marital Status

☐ Single ☐ Married ▶ Y Y Y Y M M D D Date of marriage

☐ Widowed ☐ Un-married spouse ▶ Y Y Y Y M M D D Date of cohabitation

☐ Separated ☐ Divorced ▶ Y Y Y Y M M D D Date of divorce

Are you a member in good standing of the FMOQ?

☐ Yes Member No. _____

☐ No Why? _____

Are you recent graduate? ☐ Yes ☐ No

Date of enrolment in the Collège des médecins du Québec 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.

OPTION A – PRESCRIPTION DRUG AND HEALTH CARE INSURANCE
The selection is effective for a minimum period of two years. Select Option R, A, B or C or fill out the EXEMPTION section.

Status: ☐ INDIVIDUAL ☐ SINGLE-PARENT ☐ COUPLE ☐ FAMILY

☐ OPTION R	☐ OPTION A	☐ OPTION B	☐ OPTION C PRESCRIPTION DRUG INSURANCE AND RAMQ
Deductible: $267 Coinsurance: According to RAMQ Maximum annual contribution per adult: • The RAMQ maximum amount Coverage: • Prescription Drugs - RAMQ List	Deductible: $300 Prescription drug coinsurance: 80% Maximum annual contribution per adult: • The RAMQ maximum amount Coverage: • Drugs that can only be obtained on prescription • Travel and trip cancellation insurance	Deductible: • $600 - (plan members under 65) • $267 - (plan members 65 and over) Coinsurance: 75% Maximum annual contribution per adult: • The RAMQ maximum amount Coverage: • Prescription drugs only • Travel and trip cancellation insurance • Medical and paramedical expenses	Deductible: • $150 - Individual and Single-Parent • $300 - Couple and Family Coassurance : 66 % Maximum annual contribution per adult: • The RAMQ maximum amount Coverage: • Prescription Drugs - RAMQ List

☐ **OPTION L – DENTAL CARE INSURANCE**
- **This option is only available for doctors who selected Option B (health care coverage).**
- **The coverage status for dental care must be the same as for health care coverage.**
- **The minimum participation period is 3 years.**

Coinsurance:
• 80%: Diagnosis and prevention
• 75%: Basic care
• 50%: Prosthodontics

Maximum per calendar year: $2,000 per insured person for all these benefits

Please check the selected or modified coverage: ☐ Individual ☐ 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

EXEMPTION

Start of exemption ☐ ▶ Start date of exemption Y Y Y Y M M D D

Provide proof of an insurance allowing the exemption.

End of exemption ☐ ▶ End date of exemption Y Y Y Y M M D D

Provide reason for the end of the insurance allowing the exemption on the Information line on the right.

Information: _____

INFORMATION ABOUT DEPENDENTS

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

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

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

Child's full name:	Sex	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 SSQ Insurance, its employees, its agents, its reinsurers and its service providers who are responsible for contract management, investigations, underwriting and processing claims under the FMOQ'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 FMOQ. **I CONFIRM** that I have read the FMOQ 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

SSQ Insurance and Sogemec Assurances Inc. (Sogemec) protect the confidentiality of your personal information. SSQ Insurance 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 SSQ Insurance and Sogemec employees who must do so to perform their duties. SSQ Insurance may compile anonymized information for statistical and informational purposes. You have the right to access your file at SSQ Insurance 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:

SSQ Insurance
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

SSQ Insurance 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 SSQ Insurance or Sogemec.

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