

Declaration of Smoking Habits

Before declaring that you are a smoker or a non-smoker, please read the following definition (any false or incomplete declaration may result in the participant's group insurance becoming null and void):

"To be considered a non-smoker, the declarant must not under any circumstances have smoked any tobacco products such as cigarettes, cigars, cigarillos or pipes, nor consumed any drugs, during the last twelve (12) months." In any other case, the declarant is a smoker for the purposes of the group insurance contract.

It is understood that the insurer may periodically require a confirmation of non-smoker status: the participant or the spouse must be able to meet the requirements in force on that date and return the confirmation within 30 days following the insurer's request; a failure to do so means the insured loses the status of non-smoker and the reduction in premiums is no longer applicable effective as of the date the request was issued by the insurer.

PARTICIPANT: Non-smoker Smoker | SPOUSE: Non-smoker Smoker

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: _____

Gestion des 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/>