ASSIGNMENT OF BENEFITS

P.O Box 10500, Station Sainte-Foy, Quebec (Quebec) G1V 4H6

SECTION 1 - PARTICIPANT INFORMATION

SSQ CERTIFICATE NUMBER	
LAST NAME	FIRST NAME
ADDRESS	TELEPHONE NUMBER

TOWN/CITY PROVINCE POSTAL CODE

SECTION 2 – PATIENT INFORMATION

Patient Last and First Name: ____

Relationship to Participant: ____

SECTION 3 – IDENTIFICATION FOR PAYMENT

I, ________________________________, hereby request that SSQ, Life Insurance Company Inc. assign to

____________________________________ all the amounts that are owed to me in relation to the coverage that applies

for the purchase of _______________________________________. The direct payment of my insurance benefits

reimbursed in accordance with the percentages and limits stipulated in my contract shall be sent to:

____

NAME OF COMPANY

____

FULL ADDRESS

____

TELEPHONE

SECTION 4 – AUTHORIZATION

I understand that by signing this assignment of insurance benefits form, the amount reimbursed will be given directly to the company identified in Section 3. I understand that I will be financially responsible for any amount not reimbursed by the insurance company. I authorize my insurance company to disclose to that company any information necessary to process the benefit claim. I understand that the original invoice enclosed with a copy of the prescription received from my attending physician as well as this duly completed form will be sent to SSQ, Life Insurance Company Inc.

____ ____

SIGNATURE OF PARTICIPANT **DATE**

____ ____

SIGNATURE OF PATIENT OR PARENT / LEGAL GUARDIAN (if under age 18) **DATE**

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RELATIONSHIP WITH THE PATIENT IF PARENT OR LEGAL GUARDIAN