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**

_____

RELATIONSHIP WITH THE PATIENT IF PARENT OR LEGAL GUARDIAN