CONSENT TO COLLECT,USE AND DISCLOSE PERSONAL INFORMATION

ACCIDENTAL DENTAL, ACCIDENTAL MENTAL, OVERUSE INJURIES CLAIMS

SSQ Insurance Company Inc.
1225 St-Charles Street West, Suite 200, Longueuil QC J4K 0B9

I authorize SSQ Insurance Company Inc. and its authorized representatives to collect, use, and disclose personal information about me and, where applicable, my dependent children as permitted by law from and to the following persons and organizations:

- any licensed medical practitioner or licensed health professional, hospital, clinic or medically related facility;
- any other insurance company or financial institution, including any reinsurance company;
- any other person or organization with information relevant to my claim; and
- any person or organization that provides information services or insurance services to, or that acts as insurance intermediary for SSQ Insurance Company Inc.;

for the following purposes:

- establishing and maintaining communications with me;
- underwriting group risks on a prudent basis;
- investigating and settling claims;
- detecting and preventing fraud;
- offering and providing products and services to meet my needs;
- compiling insurance statistics; and
- complying with the law.

The personal information collected by SSQ Insurance Company Inc. will be entered into a file whose subject is accident and sickness insurance. The file will be kept at SSQ Insurance Company Inc. offices. Within SSQ Insurance Company Inc., this file will only be accessed by those employees who require access in order to fulfill the purposes listed above. I understand that I may access my personal information contained in this file and correct such information if necessary by directing a written request to:

Privacy Officer
SSQ Insurance Company Inc.
1225 St-Charles Street West
Suite 200
Longueuil, Quebec J4K 0B9

This consent shall be valid for the length of time necessary for SSQ Insurance Company Inc. to achieve the purposes listed above. I may withdraw this consent at any time by giving SSQ Insurance Company Inc. written notice of withdrawal. I understand that withdrawal of my consent might result in SSQ Insurance Company Inc. being unable to provide me with a product or service.

A copy of this consent shall be considered as effective and valid as the original.

Date of the occurrence D M Y Cause (accident, illness, overuse injuries, etc.): .....

.... **1PA25**

Signature of Insured Print Name Policy Number

Date D M Y Telephone ( )

Address .....

Street & Number City Province Postal Code

Where the claim is for the Accidental Death of the Insured Person, this consent must be signed by their authorized representative, and shall apply to both the Insured Person and the authorized representative:

.... D M Y

Signature of Authorized Representative Print Name Date

Relationship to the Insured: .....

The completed authorization can be returned to SSQ Insurance Company Inc. at the following address:

1225 St-Charles Street West, Suite 200, Longueuil QC J4K 0B9 or claims.spgroup@ssq.ca