

Identification of the Participant

Contract holder OPSEU LCBO Strike		Contract Number 31D99	Effective Date June 2017
Last Name		First Name	SIN
Address			Union ID
Town/City		Province	Postal Code
Date of Birth YYYY MM DD	Gender		Phone Number

Spouse and Dependent Children

Spouse's Last Name		First Name	Date of Birth YYYY MM DD
First and last name of child	Gender	Date of Birth YYYY MM DD	If full time student, name of educational institution
		YYYY MM DD	
		YYYY MM DD	
		YYYY MM DD	
		YYYY MM DD	
		YYYY MM DD	
		YYYY MM DD	

Beneficiary

The amount insured will be payable to my estate

I wish to designate the following beneficiary(ies) in the event of my death:

Name (s)	Relationship

I hereby appoint (full name/relationship) _____ as Trustee to receive any amount payable to a minor beneficiary under this policy and declare the receipt by such Trustee shall discharge the insurance company for the amount so paid. And I do hereby authorize the Trustee, within his/her discretion, to expend all or any such amount and/or the income resulting from the proceeds for the maintenance or education of such minor. (You must appoint a trustee if your beneficiary is under age 18.)

Authorization

Should the above Member Identification Number represent my Social Insurance Number, I hereby authorize The SSQ, Life Insurance Company Inc. to use my Social Insurance Number for purposes of administration of my group benefit plan. I understand that my Social Insurance Number will be kept in strictest confidence and will only be used for the purposes authorized herein.

I declare that the statements I have made on this form are complete and true. I understand that if any statement is incomplete or false, coverage may be voided.

On behalf of myself and my eligible dependents, I authorize my group benefit provider, SSQ, Life Insurance Company Inc. and any of its affiliates or reinsurers to exchange the personal information contained on this form or any other benefit-related personal information contained in their files now or in the future respecting me or any of my eligible dependents. I give my consent on the understanding that the information will be used solely for purposes of administration and management of my group benefit plan. This consent shall continue so long as I and my dependents are covered by, or are claiming benefits under the present group contract, or any modification, renewal or reinstatement thereof.

Signature	Date
-----------	------

Send this completed form to:

OJTBF - Strike Benefits
6 Lansing Square, Suite 121, Toronto, ON M2J 1T5