HealthSource Plus
Group Benefits · Administration · Wellness · Retirement

REQUEST FOR LIFE INSURANCE CONVERSION

Form 10

For more information, please call SSQ Life Conversion Department at 1-888-900-3457, extension 2629
COMPLETE THIS FORM IN BLOCK LETTERS USING INK. FORMS WITH PENCIL WILL NOT BE ACCEPTED.

A. Employer Information

Employer's Name:		Policy No:
Division No:	Unit No:	Employee Certificate No:

B. Employee Information

Last Name:	Gender ☐ M ☐ F	Birth Date: DD/MM/YY
First Name:	Language Preference: ☐ English ☐ French	SIN # :
Mailing Address:		
Home telephone:	Home e-mail:	

C. Reason for Conversion:

Termination date: D M Y

	Termination of employment ☐	Retirement ☐
	Termination of Contract ☐	End of Life Insurance Premium Waiver ☐
	Other ☐ _____	

D. Life Conversion Requested for:

Employee:	☐ Yes ☐ No	Amount to be converted $ _____
Spouse:	First Name:	Last Name:
Gender ☐ M ☐ F	Date of Birth: D M Y	Amount to be converted $ _____
Child:	First Name:	Last Name:
Gender ☐ M ☐ F	Date of Birth: D M Y	Amount to be converted $ _____
Child:	First Name:	Last Name:
Gender ☐ M ☐ F	Date of Birth: D M Y	Amount to be converted $ _____
Child:	First Name:	Last Name:
Gender ☐ M ☐ F	Date of Birth: D M Y	Amount to be converted $ _____
Child:	First Name:	Last Name:
Sex ☐ M ☐ F	Date of Birth: D M Y	Amount to be converted $ _____

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Employee Authorization

I declare that the statements I have made on this form are true and complete. I understand that if any statement is incomplete or false and/or if I do not abide by the terms and conditions as set forth in the insurance policy and/or this application for insurance, my benefits may be terminated.
I certify that I am authorized to disclose and receive information about my spouse and/or my dependents.
I hereby authorize HealthSource Plus Inc. as the administrator of my group health insurance plan to receive and maintain a record of the personal health information and claims history for myself and my dependents, and of my social insurance number (where applicable) on behalf of my employer and use such information to:

a) Verify eligibility & identify myself and/or my dependents;
b) Ensure my benefits are paid in accordance with the policy provisions;
c) Protect the plan from undue expenses due to error or fraud;
d) To allow my employer to audit, review and analyze claims trends as required.

I understand that spousal claims are only to be submitted where my spouse is not insured elsewhere or where a portion of the claim is not reimbursed under my spouses plan. I understand that dependent claims should first be submitted to the plan of the parent whose day and month of birth comes earlier in the year, and that only the portion not reimbursed may then be submitted to my plan.
I understand that HealthSource Plus Inc. shall have the right to recover from myself and/or my dependents any payments made in error or as a result of fraud, as well as any costs related directly to the recovery of such funds.
I understand that if I waive benefits now and wish to reinstate my benefits in the future, I will be required to provide at my expense, satisfactory evidence of insurability and subject to the sole discretion of HealthSource Plus Inc. my benefits may be reinstated.
I authorize my employer to deduct from my payroll any portion of the benefits program which I may be required to pay.

Name (Please Print) | Signature | Date Signed (dd/mm/yyyy)

Employer Authorization

I declare that the information provided on this form is complete and accurate to the best of my knowledge, and **I authorize** HealthSource Plus to use this information to administer the group benefits plan; obtain quotes for underwritten/insured products within the plan; verify the identity and eligibility of the plan member, spouse or eligible dependents; adjudicate and pay eligible claims; audit plan expenditures; and, prepare reports.
I understand this information will only be provided to those insurers/adjudicators contracted by HealthSource Plus to provide services within the plan.
I declare that I have obtained the Consent of this Employee (and the consent of the spouse or partner where applicable) to provide this information to HealthSource Plus.

Name (Please Print) | Signature | Date Signed (dd/mm/yyyy)

HealthSource Plus Authorization

Date of Employment: _____ Date of Termination: _____

HSP Certificate Number: _____ SSQ Group Number: _____

Company Name: _____ SSQ Class Number: _____

Confirmation of Salary: _____

HSP Representative Name (Please Print) | Signature | Date Signed (dd/mm/yyyy)