



11101

Delta 3 Building
2875 Laurier Blvd, Suite 400
P.O. Box 1500
Québec QC G1K 8X9
Email:

Telephone: 418 644-4200
1 800 463-4856
Fax: 418 646-1313
adm.collectif@lacapitale.com

- Temporary work interruption
 Return to work

GROUP No.	EMPLOYER No.	IDENTIFICATION No.

1 - INFORMATION ABOUT PARTICIPANT

LAST NAME		FIRST NAME			
ADDRESS	No.	STREET	APT.	TEL. HOME	()
TOWN/CITY	POSTAL CODE		TEL. WORK	()	

2 - TERMINATION OF PAYMENT

Check the reason	Start date of leave or date of event (year-month-day)	Date of return to work (year-month-day)
<input type="checkbox"/> Salary insurance	_____	_____
<input type="checkbox"/> Disability retirement	_____	_____
<input type="checkbox"/> Retirement	_____	_____
<input type="checkbox"/> Resignation	_____	_____
<input type="checkbox"/> Dismissal	_____	_____
<input type="checkbox"/> Revocation (2 years of disability)	_____	_____
<input type="checkbox"/> Death	_____	_____
<input type="checkbox"/> * Temporary layoff	_____	_____
<input type="checkbox"/> * Suspension	_____	_____
<input type="checkbox"/> ** Leave without pay	_____	_____
<input type="checkbox"/> ** Leave without pay following parental leave	_____	_____
<input type="checkbox"/> * Dismissal contested by grievance	_____	_____
<input type="checkbox"/> * Termination of employment (occasional employee eligible for insurance)	_____	_____
<input type="checkbox"/> Other (specify) _____	_____	_____

* The participant may maintain coverage for all benefits except salary insurance.
** The participant may maintain coverage for all benefits.

3- PARTICIPANT'S DECLARATION

I hereby declare that I wish to:

- Maintain my group insurance benefits
 Cancel all group insurance benefits except the mandatory health insurance plan that includes prescription drug insurance

Signed at _____, on this _____ day of _____, 20 ____.

Signature _____

Note: If neither of the boxes in this section is marked, or if this form is unsigned, all of the participant's optional benefits will be suspended from the start date of absence. To restore coverage under these benefits, the participant must return this form to the Insurer, completed and signed, during the first 31 days of absence. In such a case, premiums are payable as of the start date of absence.

4 - SIGNATURE OF EMPLOYER'S REPRESENTATIVE

Signed at _____, on this _____ day of _____, 20 ____.

Signature _____ (_____) Telephone No. _____

Employers may reproduce this form as their individual needs require.