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EXEMPTION

- Application for exemption
- Termination of exemption

GROUP NO.	EMPLOYER NO.	IDENTIFICATION NO.

1 – INFORMATION ABOUT PARTICIPANT

LAST NAME		FIRST NAME	
ADDRESS NO.	STREET	APT.	HOME TEL. ()
TOWN/CITY	POSTAL CODE	WORK TEL. ()	
SOCIAL INSURANCE NO.	DATE OF BIRTH (Year-Month-Day)	EMPLOYMENT DATE (Year-Month-Day)	

IMPORTANT: ALL APPLICATIONS MUST BE SUBMITTED WITHIN 30 DAYS FOLLOWING THE EVENT

2 – APPLICATION FOR EXEMPTION

Name of person insuring participant as a dependent : _____

Relation to participant : _____

Name of employer through which this person is insured : _____

Name of insurer : _____

Reason for requesting exemption : _____

Eligibility date : _____

I hereby wish to opt out of participation in the following insurance plan(s):

- Basic Health Insurance Complementary Health Insurance (if specified in contract) Dental Care Insurance (if specified in contract)

as I have been insured since _____ as a participant or dependent under a group insurance contract containing similar benefits.

ENCLOSE A COPY OF YOUR INSURANCE CERTIFICATE FROM THE PREVIOUS INSURER SHOWING THE COVERAGE HELD

3 – TERMINATION OF EXEMPTION

Name and date of birth of individual(s) to be insured : _____

(other than participant) : _____

Relation to participant : _____

Name of previous insurer : _____

Is it **IMPOSSIBLE** for you to remain covered with the previous insurer? : Yes No

If yes, for which insurance benefits? _____

Reason for termination of coverage with previous insurer : _____

Date of termination of coverage with previous insurer : _____

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4 – SIGNATURES

"I understand that any acceptance of my application by La Capitale Insurance and Financial Services Inc. is subject to the provisions of the contract under which I am covered."

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

Signature of participant

Signature of witness (other than participant)

5 – SIGNATURE OF EMPLOYER

Signature of employer

Date