La Capitale Civil Service Insurer Inc.
625 Jacques-Parizeau St, PO Box 1500, Quebec QC G1K 8X9
418 644-4200 or 1 800 463-4856

INFORMATION CONCERNING DEPENDENTS

Group No.	Employer No.	Identification No.

1. INFORMATION ABOUT PARTICIPANT

Last name	First name	Date of birth (YYYY/MM/DD)

No., street, apt.	City

Province	Postal code	Main phone	Ext.	Phone (other)	Ext.

Civil Status ☐ Single ☐ Married or civil union ☐ Common-law spouse ☐ Widowed ☐ Divorced ☐ Separated — Since (YYYY/MM/DD)

2. INFORMATION ABOUT DEPENDENTS

Spouse

Last name and first name: _____

Date of birth: _____ (year-month-day) Gender: ☐ M ☐ F

Child	Name of institution attended	Full-time student[1] or child with a functional impairment[2]
First name: _____ Last name: _____ Date of birth: _____ (year-month-day) Gender: ☐ M ☐ F	_____	☐ Full-time student From _____ to _____ ☐ Functional impairment
First name: _____ Last name: _____ Date of birth: _____ (year-month-day) Gender: ☐ M ☐ F	_____	☐ Full-time student From _____ to _____ ☐ Functional impairment
First name: _____ Last name: _____ Date of birth: _____ (year-month-day) Gender: ☐ M ☐ F	_____	☐ Full-time student From _____ to _____ ☐ Functional impairment

Note 1: Full-time student means 4 classes, 12 credits or 180 hours per session. The same criteria apply to correspondence courses offered by recognized institutions. | **Note 2:** Please contact customer service for how to proceed.

3. SIGNATURE

I hereby state that the aforementioned information is complete, true and in conformity with the condition and dispositions of my group insurance contract. Any false declaration may result in a cancellation of the insurance.

Signed in _____, on this _____ day of _____ 20 _____.

Participant's signature _____

This form may be sent to the Insurer by mail, fax or email, using the above contact information.
If you do not send the original document, make sure you store it in a safe place.
Please note that the Insurer may require the original document at any time for audit purposes.