La Capitale
Insurance and
Financial Services

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NOTICE OF MODIFICATION

GROUP NO.	EMPLOYER NO.

1 – NAME OF THE EMPLOYER

Phone No.: ( )

2 – MODIFICATION(S)

Identification No.	Name of participant	Code	Date of modification	Specify

CODES * **You have to remain insured for the basic health insurance coverage according to the Act respecting prescription drug insurance (S.R.Q. A-29.01) for the maximum period of time stipulated in the contract, when applicable.**

CODE	REASON	SPECIFICATION
A	Departure	Indicate de reason
B	Death	
C	Change of salary	Annual salary
D	Retirement	Include the requested form
E	Return to work	Following a temporary layoff, a leave of absence, a disability period, etc.
F	Beginning of disability period	Last day of work
G	Leave of absence with participation	Maintain all guarantees
* H	Leave of absence without participation	Maintain basic health insurance
I	Temporary layoff with participation	Maintain health and life insurance
* J	Temporary layoff without participation	Maintain basic health insurance
K	Preventive withdrawal	Maintain all guarantees
L	maternity leave	Maintain all guarantees
M	Parental leave	Maintain all guarantees
N	Parental leave of absence with participation	Maintain health and life insurance
* O	Parental leave of absence without participation	Maintain basic health insurance
P	Other reason	Specify

3 – SIGNATURE OF THE EMPLOYER

Signature

Date

Each employer may reprint this form for its needs.