NOTICE OF MODIFICATION

La Capitale Civil Service Insurer Inc.
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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 * **If you are resident of the province of Quebec, you have to remain insured for the basic health insurance coverage according to the Act respecting prescription drug insurance 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.