La Capitale
Civil Service Insurer

DECLARATION OF THE EMPLOYER
EMPLOYEE'S DEATH

625 Jacques-Parizeau St.
PO Box 1500
Quebec QC G1K 8X9

Telephone: 418 644-4200
1 800 463-4856
Fax: 418 641-4321
1 855 669-8830

Email: collectif_deces@lacapitale.com

GROUP NO.	EMPLOYER NO.	IDENTIFICATION NO.

1 – PARTICIPANT'S IDENTIFICATION

LAST NAME		FIRST NAME	
ADDRESS NO. STREET APT.			PHONE AT HOME ( )
CITY		POSTAL CODE	PHONE AT WORK ( )

CIVIL STATUS SINCE ____________ ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ SEPARATED ☐ CIVIL UNION ☐ SINGLE PARENT ☐ WIDOWED

2 – DECLARATION OF THE EMPLOYER

2.1 I declare that the above-mentioned employee is covered under the above-mentioned group insurance contract for an amount of $ ____________________.

2.2 At the time of death, he or she was employed since ____________________ (Year-Month-Day)

as ____________________. (Job title)

2.3 Date of the last day of work: ____________________ (Year-Month-Day)

Annual salary on the last day of work: $ ____________________

Employment status at the time of death:

☐ Regular service

☐ Temporary absence without remuneration since __________ (Year-Month-Day) to __________ (Year-Month-Day)

☐ Vacation from __________ (Year-Month-Day) to __________ (Year-Month-Day)

☐ Early retirement __________ (Year-Month-Day)

☐ Sick leave of absence since __________ (Year-Month-Day)

☐ Retirement __________ (Year-Month-Day)

2.4 Date of death: ____________________ (Year-Month-Day)

2.5 Cause of death: ☐ Accident ☐ Illness

3 – DOCUMENTS TO SUPPLY

3.1 Please forward a copy of the membership application and/or beneficiary designation from current and former group insurance contracts.

3.2 Join a photocopy of the most recent "T4" **or** "Relevé 1" **or** pay slip.

3.3 Please provide the claimant's contact information (name, address and phone number):

____

____

4 – SIGNATURE OF THE EMPLOYER

Signed in ____________________, on the __________ day of ____________________ 20 ____.

____
Signature

Each employer may reprint this form for its needs.

LaCapitale
Insurance and Financial Services

DECLARATION OF THE EMPLOYER
DEPENDENT'S DEATH

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GROUP NO.	EMPLOYER NO.	IDENTIFICATION NO.

1 – PARTICIPANT'S IDENTIFICATION

LAST NAME FIRST NAME

ADDRESS NO. STREET APT. PHONE AT HOME ( )

CITY POSTAL CODE PHONE AT WORK ( )

CIVIL STATUS SINCE ____________ ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ SEPARATED ☐ CIVIL UNION ☐ SINGLE PARENT ☐ WIDOWED

2 – IDENTIFICATION OF DECEASED DEPENDENT

Last Name: ____________ First Name: ____________ Gender: ☐ M ☐ F

Relationship with the participant: ____________ Date of birth: ____________ (Year-Month-Day) Date of death: ____________ (Year-Month-Day)

Civil status since ____________ ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ SEPARATED ☐ CIVIL UNION ☐ SINGLE PARENT ☐ WIDOWED

3 – DECLARATION OF THE EMPLOYER

3.1 I declare that the above-mentioned **employee** is covered under the above-mentioned group insurance contract.

3.2 According to the group insurance contract, the above-mentioned **dependent** is covered for an amount of $ ____________ .

3.3 Employment status of the employee:

☐ Regular service

☐ Temporary absence without remuneration since ____________ (Year-Month-Day) to ____________ (Year-Month-Day)

☐ Vacation from ____________ (Year-Month-Day) to ____________ (Year-Month-Day)

☐ Early retirement ____________ (Year-Month-Day)

☐ Sick leave of absence since ____________ (Year-Month-Day)

☐ Retirement ____________ (Year-Month-Day)

3.4 Cause of death: ☐ Accident ☐ Illness

4 – DOCUMENTS TO SUPPLY

4.1 Join a photocopy of the most recent "T4" **or** "Relevé 1" **or** pay slip.

4.2 Please provide the claimant's contact information (name, address and phone number):

____

____

5 – SIGNATURE OF THE EMPLOYER

Signed in ____________, on the ____________ day of ____________ 20 ____.

____
Signature

Each employer may reprint this form for its needs.