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GROUP NO.	EMPLOYER NO.	IDENTIFICATION NO.

**1 – PARTICIPANT'S IDENTIFICATION**

FAMILY NAME		FIRST NAME			
ADDRESS	NO.	STREET	APT.	PHONE AT HOME	( )
CITY	POSTAL CODE		PHONE AT WORK	( )	
CIVIL STATUS SINCE _____ <input type="checkbox"/> CIVIL UNION <input type="checkbox"/> DIVORCED <input type="checkbox"/> MARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> SINGLE <input type="checkbox"/> SINGLE PARENT <input type="checkbox"/> WIDOWED					

**2 – IDENTIFICATION OF DEPENDENT**

Family Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Gender:  M  F

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

Civil status since \_\_\_\_\_  CIVIL UNION  DIVORCED  MARRIED  SEPARATED  SINGLE  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 \_\_\_\_\_ to \_\_\_\_\_  
(Year-Month-Day) (Year-Month-Day)

Vacation from \_\_\_\_\_ to \_\_\_\_\_  Early retirement \_\_\_\_\_  
(Year-Month-Day) (Year-Month-Day)

Sick leave of absence since \_\_\_\_\_  Retirement \_\_\_\_\_  
(Year-Month-Day) (Year-Month-Day)

3.4 Death cause :  Accident  Illness

**4 – DOCUMENTS TO SUPPLY**

- 4.1 Join a photocopy of the most recent "T4" **or** "Relevé 1" **or** pay register.
- 4.3 Please, forward the claimant's 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.