Declaration of insurability

Dental Care Insurance Plan
Group Insurance

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 • Fax: 418 646-1313 • adm.collectif@lacapitale.com

Group No.	Employer No.	Identification No.

1 INFORMATION ABOUT PROPOSED INSURED

PARTICIPANT (you)

Last name and first name	Name at birth (if different)	Gender ☐ M ☐ F	Date of birth (YYYY/MM/DD)

No., Street, Apt.	City

Province	Postal Code	Main telephone No.	Ext.	Telephone (Other)	Ext.

IMPORTANT: If you are a retired participant who has left the labour market, please skip the next question and proceed directly to providing identifying information concerning your spouse.

Are you currently at work? ☐ Yes ☐ No	If not, as of when? Year / Month / Day	Reason for absence from work :

SPOUSE (if coverage is desired)

Last name and first name	Name at birth (if different(	Gender ☐ M ☐ F	Date of birth (YYYY/MM/DD)

CHILDREN (if coverage is desired) I **IMPORTANT:** *Please use a second form if you have more than two chidren.*

	Last name and first name	Gender ☐ M ☐ F	Date of birth (YYYY/MM/DD)
Child 1			
Child 2			

IMPORTANT: The following question must be filled in for every coverage status (individual, family, couple or single-parent coverage status).

Have you or any proposed insured ever held coverage under a Dental Care Insurance plan? ☐ Yes ☐ No	If so, please indicate the termination date of coverage Year / Month / Day	First name(s): _____ Reason for end of coverage? _____

2 CONSULTATIONS INFORMATION

Proposed insured	Date of last complete examination by dentist, denturist or specialist (YYYY/MM/DD)	Date of last treatment by dentist, denturist or specialist (YYYY/MM/DD)	Name and address of dentist, denturist or specialist
Participant			
Spouse			
Child 1			
Child 2			

3 DENTAL HEALTH INFORMATION

Has the proposed insured:	Participant	Spouse	Child 1	Child 2
1. Consulted for examinations or dental treatment during the last 2 years? **If so, please provide details in Section 4.**	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
2. Undertaken dental treatment that is yet to be completed? **If so, please provide details in Section 4.**	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
3. Will require dental treatment during the next 6 months? **If so, please provide details in Section 4.**	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
4. Been told by their dentist, denturist or specialist that they will require dental treatment? **If so, please provide details in Section 4.**	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
5. Have a complete or partial dental prosthesis (denture)?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Date last changed (YYYY/MM/DD):	_____	_____	_____	_____
If so, please provide details in Section 4.	☐ Complete ☐ Partial	☐ Complete ☐ Partial	☐ Complete ☐ Partial	☐ Complete ☐ Partial

4 EXPLANATIONS

To be completed for each of the YES answers in Section 3. If necessary, please use a second form dated and signed by the proposed insured, or by the proposed insured's legal guardian, if he or she is less than 18 years of age, and attach it to this form.

Question	Name of person concerned	Dental Care and Treatment		Name and address of dentist, denturist or specialist
		Current	Upcoming	

5 AUTORIZATION AND DECLARATION

If you are submitting an application for a person age 18 or over, that person must provide consent and sign below.

"**I authorize** any physician, any dentist, any other professional and any intervening party in the field of health and rehabilitation, as well as any public or private health and social services institution, any insurance company, as well as any reinsurer, any public or private organization, any information agency that may receive such a mandate, any market intermediary, any employer or ex-employer, the policyholder as well as any person holding personal files or information, particularly medical records pertaining to myself, as the case may be, to provide to La Capitale Civil Service Insurer Inc. (La Capitale) or its agents or mandataries, any information it may hold that may be required for the processing of my file.

I also authorize La Capitale to transmit such information to the aforementioned persons when necessary, within the scope of its activities and the processing of my file."

This authorization shall be valid for the purposes of this contract and for any amendments, extensions or renewals thereof. A photocopy of this authorization shall be considered as valid as the original.

"I hereby confirm that the information provided in this form is true and complete, in the knowledge that La Capitale shall base its decision to approve or decline my applicationon this information. I further understand that any incomplete, inaccurate, false or deceitful declarations may cause my insurance contract to be cancelled."

X _____ Date : _____
Participant's signature or, if a minor, signature of legal guardian — YYYY/MM/DD

X _____ Date : _____
Spouse's signature — YYYY/MM/DD

X _____ Date : _____
Signature of dependent age 18 or over — YYYY/MM/DD

X _____ Date : _____
Signature of dependent age 18 or over — YYYY/MM/DD

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.