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GROUP NO.	EMPLOYER NO.
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<b>A- PARTICIPANT'S LAST NAME (MAIDEN NAME IF APPLICABLE) FIRST NAME</b>					IDENTIFICATION NO.	
ADDRESS	NO.	STREET	APT.	CITY	PROVINCE	POSTAL CODE
TELEPHONE HOME: ( ) -		WORK: ( ) -		CURRENT DUTIES (employment)	ARE YOU CURRENTLY WORKING? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF NO, WHY NOT?

**B- TO BE COMPLETED BY THE PARTICIPANT IN ALL CASES (INDIVIDUAL, FAMILY OR SINGLE-PARENT COVERAGE STATUS)**

**HAVE ANY OF THE PROPOSED INSUREDS EVER HELD COVERAGE UNDER A DENTAL CARE INSURANCE PLAN?**  YES  NO

IF YES, DATE COVERAGE ENDED: \_\_\_\_/\_\_\_\_/\_\_\_\_ Year / Month / Day First Name \_\_\_\_\_

REASON FOR END OF COVERAGE: \_\_\_\_\_

**C- PLEASE PROVIDE THE FOLLOWING INFORMATION FOR EACH OF THE PROPOSED INSUREDS:**

	FIRST NAME	DATE OF BIRTH	DATE OF LAST COMPLETE EXAMINATION BY DENTIST, DENTURIST OR SPECIALIST	DATE OF LAST TREATMENT BY DENTIST, DENTURIST OR SPECIALIST	NAME AND ADDRESS OF DENTIST, DENTURIST OR SPECIALIST
<b>PARTICIPANT</b>					
<b>SPOUSE</b>					
<b>CHILD</b>					
<b>CHILD</b>					
<b>CHILD</b>					

**D- PLEASE SPECIFY WHETHER ANY OF THE PROPOSED INSUREDS: (FOR YES ANSWERS, SPECIFY BELOW)**

	PARTICIPANT		SPOUSE		CHILDREN	
	YES	NO	YES	NO	YES	NO
1) HAVE CONSULTED FOR EXAMINATIONS OR DENTAL TREATMENT DURING THE LAST 2 YEARS?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2) HAVE COMMENCED DENTAL TREATMENT THAT IS YET TO BE COMPLETED?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3) WILL REQUIRE DENTAL TREATMENT DURING THE NEXT 6 MONTHS?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4) HAVE BEEN TOLD BY THEIR DENTIST, DENTURIST OR SPECIALIST THAT THEY WILL REQUIRE DENTAL TREATMENT?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5) HAVE A <input type="checkbox"/> COMPLETE OR <input type="checkbox"/> PARTIAL DENTAL PROSTHESIS (DENTURE)? <b>DATE LAST CHANGED:</b> ____/____/____ Year / Month / Day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**EXPLANATION OF YES ANSWERS:**

QUESTION NO.	FIRST NAME	DENTAL CARE AND TREATMENT		NAME AND ADDRESS OF DENTIST, DENTURIST OR SPECIALIST
		CURRENT	UPCOMING	

**E- DECLARATION**

I hereby declare that the answers to the questions above are true and complete, and I acknowledge that any application for insurance completed will be governed by the terms and conditions of a contract pertaining to each of the above-mentioned proposed insureds. I also understand that the insurance described herein shall only come into force for any of the proposed insureds once La Capitale Insurance and Financial Services Inc. has approved the application and communicated its decision to the proposed insured. This application shall be considered declined if it is not approved by the Head Office of La Capitale Insurance and Financial Services Inc. within sixty (60) days following the date on which it was completed. I also understand that any misrepresentation may result in the cancellation of my insurance.

Signed at \_\_\_\_\_ on \_\_\_\_/\_\_\_\_/\_\_\_\_ Year / Month / Day

Participant \_\_\_\_\_ Spouse \_\_\_\_\_

**F- AUTHORIZATION**

I authorize any physician, 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 Insurance and Financial Services Inc. (hereafter 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.

If you have applied for Family or Single-Parent coverage status, the authorization of your spouse and dependent children age 18 or over is also required.

Signature of participant or, if a minor, signature of legal guardian \_\_\_\_\_ Date \_\_\_\_\_ Signature of spouse \_\_\_\_\_ Date \_\_\_\_\_

Signature of dependent age 18 or over \_\_\_\_\_ Date \_\_\_\_\_ Signature of dependent age 18 or over \_\_\_\_\_ Date \_\_\_\_\_