



11201

MEMBERSHIP APPLICATION TO GROUP INSURANCE
(COMPLETE 1-2-4-5-6-7)

MODIFICATIONS TO GROUP INSURANCE
(COMPLETE 1-2-3-4-6-7 AND 5 IF NECESSARY)

ADVANTAGE 2-9

La Capitale Insurance and Financial Services Inc.

Delta 3 Building, 2875 Laurier Blvd, Suite 400, P. O. 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 RELATING TO PARTICIPANT

NAME OF THE GROUP		NAME OF THE EMPLOYER		EMPLOYEE NO.	
FAMILY NAME		FIRST NAME		GENDER <input type="checkbox"/> M <input type="checkbox"/> F	
DATE OF BIRTH		Y		M D	
ADDRESS NO. STREET		APT.		CORRESPONDENCE <input type="checkbox"/> E <input type="checkbox"/> F	
PHONE AT HOME ()		CITY		POSTAL CODE	
PHONE AT WORK ()		CIVIL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> COMMON LAW SPOUSE <input type="checkbox"/> DIVORCED <input type="checkbox"/> SEPARATED <input type="checkbox"/> CIVIL UNION		TIME WORK <input type="checkbox"/> FULL <input type="checkbox"/> PARTIAL : _____ (%) OR _____ (WKLY/HRS)	
SINCE: Y M D		JOB TITLE		ANNUAL SALARY	
EMPLOYMENT DATE		Y M D		ELIGIBILITY DATE	
Y M D		STATUS <input type="checkbox"/> PERMANENT <input type="checkbox"/> OTHER (SPECIFY) :			

2- COVERAGE(S)

MANDATORY COVERAGE FOR EMPLOYEES

BASIC HEALTH INSURANCE

- INDIVIDUAL COVERAGE
- FAMILY COVERAGE
- EXEMPTION**

BASIC LIFE INSURANCE

- INDIVIDUAL COVERAGE
- FAMILY COVERAGE

OPTIONAL COVERAGE FOR EMPLOYEES

ADDITIONAL HEALTH INSURANCE

- INDIVIDUAL COVERAGE
- FAMILY COVERAGE

PARTICIPANT'S OPTIONAL LIFE INSURANCE*:

FROM 1 TO 10 UNITS OF \$10,000 = _____ UNITS

YES

SPOUSE'S OPTIONAL LIFE INSURANCE*:

FROM 1 TO 10 UNITS OF \$10,000 = _____ UNITS

YES

OPTIONAL COVERAGE FOR EMPLOYERS (Mandatory if employer selected one or more of these options)

DENTAL CARE INSURANCE

- INDIVIDUAL COVERAGE
- FAMILY COVERAGE
- EXEMPTION**

SHORT-TERM DISABILITY INSURANCE*

YES

LONG-TERM DISABILITY INSURANCE*

YES

IMPORTANT: * FILL OUT THE EVIDENCE OF INSURABILITY FORM

** TO BE EXEMPTED FOR HEALTH OR DENTAL CARE INSURANCE, THE EMPLOYEE MUST PROVE TO HIS EMPLOYER THAT HE OR SHE IS COVERED UNDER ANOTHER PLAN OFFERING SIMILAR BENEFITS.

DIRECT DEPOSIT SERVICE FOR REIMBURSEMENT OF HEALTHCARE EXPENSES

I authorize La Capitale Insurance and Financial Services Inc. to deposit my Health Insurance and/or

Dental Care Insurance benefits in my bank account. **(Please complete the following bank information; no cheque specimen is required).**

_____	_____	_____
Branch No.	Institution No.	Account No.

3- MODIFICATIONS

REASON(S) _____ <small>LEAVE OF ABSENCE, PARENTAL LEAVE, MATERNITY, TEMPORARY LAY OFF, BIRTH, MARRIAGE, DISABILITY, ETC.</small>	EFFECTIVE DATE Y M D
PLEASE : A) <input type="checkbox"/> MODIFY MY GROUP INSURANCE COVERAGE(S) CHECK (✓) AGAIN ALL COVERAGES CHOSEN (PART 2) B) <input type="checkbox"/> RETAIN ALL COVERAGES IN MY GROUP INSURANCE C) <input type="checkbox"/> CANCEL ALL COVERAGES IN MY GROUP INSURANCE EXCEPT DRUG INSURANCE COVERAGE	DATE OF RETURN (IF APPLICABLE) Y M D

4- IDENTIFY YOUR DEPENDENTS

First name	Family name	Gender	Date of birth	First name	Family name	Gender	Date of birth
Spouse: _____	_____	<input type="checkbox"/> M <input type="checkbox"/> F	Y M D	Children(s): _____	_____	<input type="checkbox"/> M <input type="checkbox"/> F	Y M D
Children(s): _____	_____	<input type="checkbox"/> M <input type="checkbox"/> F		_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F	
_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F		_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F	

5- BENEFICIARY'S FULL NAME (FOR LIFE INSURANCE COVERAGES)

ATTENTION: THE DESIGNATION OF AN IRREVOCABLE BENEFICIARY INVOLVES SIGNIFICANT CONSEQUENCES. HIS CONSENT WILL BE ABSOLUTELY NECESSARY IF YOU WANT TO REPLACE HIM AND, IF A MINOR, THE CONSENT OF HIS TUTOR WILL HAVE TO BE OBTAINED.

DESIGNATION: _____

RELATIONSHIP WITH THE PARTICIPANT: _____

MARK YOUR CHOICE
 REVOCABLE IRREVOCABLE

6- DECLARATION OF THE PARTICIPANT

«I hereby authorize my employer to deduct the required premiums from my salary, La Capitale Insurance and Financial Services Inc. (hereinafter mentioned La Capitale) and the person responsible for the plan to use my social insurance number for administration. Furthermore, I authorize any physician, any other professional and intervening party in the field of health and rehabilitation, as well as any public or private health or social services institution, any insurance company, as well as any reinsurer, any public or private organization, any information agency that will have received such a mandate, any market intermediary, any employer or ex-employer, the policyholder as well as any person holding personal files or information, especially medical records pertaining to me, as the case may be, to provide to La Capitale or to its mandataries, any information that it holds, 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. In the event of death, I specifically authorize the policyholder, the employer, the beneficiary, the heir or the liquidator of my succession to provide La Capitale or its mandataries when necessary, with all information or authorizations permitting the processing of my file.»

This consent is valid for the purposes of this contract, its amendment, extension or renewal. A photocopy of this consent has the same value as the original.

Signature of the participant or, if under age, that of his or her legal representative _____ () - _____ Date _____
Phone number _____

(PLEASE CONSULT THE NOTICE)

7- SIGNATURE OF THE EMPLOYER

Signature of the employer _____ () - _____ Date _____
Phone number _____

Please preserve a copy (employee and employer) and transmit the original to La Capitale.

NOTICE

La Capitale Insurance and Financial Services Inc. (hereafter La Capitale), wishes to advise you that information collected during this transaction will be kept in a file under the subject of "Group Insurance". Access to this file is restricted to employees and agents of the company, on a need-to-know basis, as required to fulfil their duties or carry out their assignments. Notwithstanding exceptions provided for by law, no other person may access your file without your authorization. Your file will be kept at the address below.

You may access your file by submitting a request in writing to the information Access Officer in the Administration Department. If any of your personal information is inaccurate, incorrect or incomplete, you may submit a request in writing to have it corrected.

When you take out a contract with La Capitale, your name and address are included in our client database to help us provide you with quality service and information on new products designed to meet your needs. If you would prefer to have your contact details removed from our distribution list, please call or write to let us know.

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Delta III Building

2875 Laurier Blvd, Suite 400

P.O. Box 1500

Quebec QC G1K 8X9

Customer Service

Telephone: 418 644-4200

or

Toll free: 1 800 463-4856