



11201

RETIREES AGE 65 AND OVER

MEMBERSHIP APPLICATION TO GROUP INSURANCE

MODIFICATION(S) TO GROUP INSURANCE

Insurance and Financial Services Inc.

Delta 3 Building, 2875 Laurier Blvd, Suite 400, P. O. Box 1500, Quebec QC G1K 8X9
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GROUP NO.	EMPLOYER NO.	IDENTIFICATION NO.
1011	9999	

1- INFORMATION RELATING TO PARTICIPANT

NAME OF THE GROUP: FÉDÉRATION NATIONALE DES ENSEIGNANTS ET ENSEIGNANTES DU QUÉBEC (CSN) RETIREMENT DATE: Y M D

FAMILY NAME: _____ FIRST NAME: _____ GENDER: M F ANNUAL SALARY BEFORE RETIREMENT: _____

NO. STREET APT. CORRESPONDENCE: E F DATE OF BIRTH: Y M D

CITY POSTAL CODE PHONE AT HOME ()

CIVIL STATUS: Y M D
 SINGLE MARRIED WIDOWED COMMON LAW SPOUSE DIVORCED SEPARATED CIVIL UNION SINCE: _____

FUNCTION OCCUPIED BEFORE THE RETIREMENT:
 TEACHER OTHER, SPECIFY: _____

2- HEALTH INSURANCE

A. BASIC HEALTH INSURANCE (Plan identical to the one proposed by the RAMQ) (The additional premium applies)

I wish to keep this benefit (Note: If you decide to sign up for this coverage, please notify the RAMQ of this in writing)

Individual coverage Family coverage Exempted

I do not want to keep this benefit

B. SUPPLEMENTAL HEALTH INSURANCE (Other medical expenses)

I wish to keep this benefit

Individual coverage Family coverage Exempted

I do not want to keep this benefit

3- LIFE INSURANCE

BASIC LIFE

I wish to keep this benefit
Fixed amount: \$5,000

OPTIONAL LIFE

I wish to keep this benefit (Enter your choice)

under age 70: from 1 to 10 unit(s) of \$5,000: choose: _____ }
age 70 and over: from 1 to 8 unit(s) of \$5,000: choose: _____ }
age 65 to 69: from 1 to 8 unit(s) of \$5,000: choose: _____ }
age 70 and over: from 1 to 2 unit(s) of \$5,000: choose: _____ }

DEPENDENT'S LIFE

I wish to keep this benefit
 I do not want to keep this benefit

If the retirement date is on or after January 1, 2004
Before January 1, 2004

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	A M J	Children: _____	_____	<input type="checkbox"/> M <input type="checkbox"/> F	A M J
Children: _____	_____	<input type="checkbox"/> M <input type="checkbox"/> F		_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F	

5- SURNAME AND GIVEN NAME OF BENEFICIARY (FOR LIFE INSURANCE BENEFITS)

APPOINTMENT: _____ REVOCABLE IRREVOCABLE

RELATIONSHIP TO PARTICIPANT: _____

VERY IMPORTANT: THE APPOINTMENT OF AN IRREVOCABLE BENEFICIARY HAS IMPORTANT CONSEQUENCES, NAMELY BECAUSE THE BENEFICIARY'S CONSENT WILL BE REQUIRED TO REPLACE HIM OR HER.

6- MODE OF PAYMENT

A. C.A.R.R.A.
As a beneficiary of the *Commission administrative des régimes de retraite et d'assurances* (C.A.R.R.A.), I authorize this organism to make a monthly deduction of required contribution from my pension cheque until a stop notice from me.
Participant's signature: _____ Date: _____

B. PLEASE BILL ME ONCE A YEAR
Participant's signature: _____ Date: _____

C. PREAUTHORIZED DEBIT AGREEMENT – TYPE OF PAD: PERSONAL
I, the undersigned, hereby authorize La Capitale Insurance and Financial Services Inc. (La Capitale) or its mandatary to debit the fixed monthly amounts required for payment of the sums due to La Capitale from the account indicated on the enclosed cheque specimen or from the account identified hereafter. Payments will be debited on the 15th of every month.

Bank account information: Please enclose a cheque specimen or indicate the transit, bank and account numbers.

_____	_____	_____
Transit	Bank	Account

You will receive notice at least ten (10) days prior to the scheduled date of the first PAD confirming the amount and date of the PADs. This agreement may be cancelled upon receipt by La Capitale of thirty (30) days' written notice prior to the scheduled date of the next PAD. Furthermore, you have certain recourse rights if any debit does not comply with this agreement. For example, you have the right to receive reimbursement for any PAD that is not authorized or is not consistent with this agreement. To obtain a sample PAD cancellation form, or for more information about your right to cancel this agreement or your other rights to recourse, contact La Capitale or visit www.cdnpay.ca.

Signature(s) according to requirements for withdrawals from this account _____ Date: _____

7- DECLARATION OF THE PARTICIPANT

"I hereby authorize La Capitale Insurance and Financial Services Inc. (hereinafter mentioned La Capitale) to use my social insurance number for identification and administration. Furthermore, I authorize any physician, any other professional and intervening party in the field of health an 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, 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 forward this information to the aforementioned persons when necessary, within the scope of their activities and the processing of my file. In the event of death, I expressly authorize the policyholder, the employer, the beneficiary, the heir or the liquidator of my succession, to provide La Capitale or it mandataries all information or authorizations making the processing of my file possible." This consent is valid for the purposes of this contract, its amendment, extension or renewal. A photocopy of this consent has the same value at the original copy.

Participant's signature _____ Telephone _____ Date _____

(PLEASE READ THE NOTICE ON THE REVERSE SIDE)

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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Quebec QC G1K 8X9

Customer Service

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or

Toll free: 1 800 463-4856