La Capitale

11201

PARTICIPATION IN GROUP INSURANCE
RETIREES AGE 65 AND OVER

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.
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

ADDRESS: 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: _____

2- HEALTH INSURANCE

A. BASIC HEALTH INSURANCE (Plan identical to the one proposed by the RAMQ)

☐ 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

☐ 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

☐ I do not want to keep this benefit

3- LIFE INSURANCE

A. BASIC LIFE

☐ I wish to keep this benefit **(Enter your choice)**

Basic life: $5,000

Optional life:	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: _____

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

Before January 1, 2004

B. DEPENDENT'S LIFE

☐ I wish to keep this benefit

☐ I do not want to keep this benefit

4- IDENTIFY YOUR DEPENDENTS

	First name	Family name	Gender	Date of birth (A M J)		First name	Family name	Gender	Date of birth (A M J)
Spouse:			☐ M ☐ F		Children:			☐ M ☐ F	
Children:			☐ M ☐ F					☐ M ☐ F	

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

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, AND IF THE BENEFICIARY IS UNDER AGE, THE TUTOR'S CONSENT MUST BE OBTAINED.

APPOINTMENT: _____ ☐ REVOCABLE ☐ IRREVOCABLE

RELATIONSHIP TO PARTICIPANT: _____

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.

_____ Date: _____

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

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)

White copy: Insurer - Yellow copy: Retiree