

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.
1008		

1- INFORMATION RELATING TO PARTICIPANT		NAME OF THE GROUP F.N.E.E.Q. (Public College)		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	
NO. STREET ADDRESS		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 OR <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		SINCE: Y M D		TIME WORK <input type="checkbox"/> FULL <input type="checkbox"/> PARTIAL : _____ (%) OR _____ (WKLY/HRS)			
JOB TITLE		ANNUAL SALARY		EMPLOYMENT DATE Y M D		ELIGIBILITY DATE Y M D	
						STATUS <input type="checkbox"/> PERMANENT <input type="checkbox"/> CONTRACTUAL	

2- COVERAGE(S)	APPLICATION	MODIFICATIONS	
		I ADD	I REMOVE
COMPULSORY COVERAGE:			
- BASIC & SUPPLEMENTARY HEALTH INSURANCE: INDIVIDUAL PLAN	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SINGLE PARENT (without spouse)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
COUPLE PLAN (if provided under the contract)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
FAMILY PLAN	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
EXEMPTION*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- DENTAL CARE (if in force in your establishment):			
INDIVIDUAL PLAN	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SINGLE PARENT (without spouse)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
COUPLE PLAN (if provided under the contract)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
FAMILY PLAN	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
EXEMPTION*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- LONG TERM DISABILITY INSURANCE: IF TEACHER ACQUIRE TENURE ON OR AFTER AUGUST 15, 2001	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
OPTIONAL COVERAGE:			
- BASIC LIFE & DEATH & DISMEMBERMENT: WITH DEPENDENT'S LIFE INSURANCE COVERAGE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
WITHOUT DEPENDENT'S LIFE INSURANCE COVERAGE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- SUPPLEMENTARY LIFE INSURANCE: MEMBER'S LIFE - FROM 1 TO 7 UNIT(S) OF \$20,000	_____ x \$20,000	_____ x \$20,000	_____ x \$20,000
(join the "Evidence of Insurability" form)			
SPOUSE'S LIFE - FROM 1 TO 7 UNIT(S) OF \$20,000	_____ x \$20,000	_____ x \$20,000	_____ x \$20,000
- LONG TERM DISABILITY INSURANCE: IF NON PERMANENT PERSONAL	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Evidence of insurability are required if the employee has completed more than 3 contracts in the same college			

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

3- MODIFICATIONS	EFFECTIVE DATE Y M D
REASON(S) _____	
PLEASE: LEAVE OF ABSENCE, PARENTAL LEAVE, MATERNITY, TEMPORARY LAY OFF, BIRTH, MARRIAGE, DISABILITY, ETC.	
A) <input type="checkbox"/> MODIFY MY GROUP INSURANCE COVERAGE(S) (PART 2)	DATE OF RETURN (IF APPLICABLE) Y M D
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	

4- IDENTIFY YOUR DEPENDENTS			
First name	Family name	Gender	Date of birth Y M D
Spouse: _____	_____	<input type="checkbox"/> M <input type="checkbox"/> F	_____
Children: _____	_____	<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: _____	MARK YOUR CHOICE <input type="checkbox"/> REVOCABLE <input type="checkbox"/> IRREVOCABLE
RELATIONSHIP WITH THE PARTICIPANT: _____	

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 identification and 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 policy holder 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 _____ () - _____ Phone number _____ Date _____
(PLEASE CONSULT THE NOTICE ON THE BACK)

7- SIGNATURE OF THE EMPLOYER
_____ () - _____ Phone number _____ Date _____

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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2875 Laurier Blvd, Suite 400

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Quebec QC G1K 8X9

Customer Service

Telephone: 418 644-4200

or

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