



- Application for exemption  
 Termination of exemption

Delta III Building  
 2875 Laurier Blvd, Suite 400  
 P.O. Box 1500  
 Québec QC G1K 8X9  
 Email:

Telephone: 418 644-4200  
 1 800 463-4856  
 Fax: 418 646-1313  
 adm.collectif@lacapitale.com

GROUP NO.	EMPLOYER NO.	IDENTIFICATION NO.

**1 – INFORMATION ABOUT PARTICIPANT**

LAST NAME		FIRST NAME	
ADDRESS NO.	STREET	APT.	HOME TEL. ( )
TOWN/CITY	POSTAL CODE	WORK TEL. ( )	
SOCIAL INSURANCE NO.	DATE OF BIRTH (Year-Month-Day)	EMPLOYMENT DATE (Year-Month-Day)	

**IMPORTANT: ALL APPLICATIONS MUST BE SUBMITTED WITHIN 30 DAYS FOLLOWING THE EVENT**

**2 – APPLICATION FOR EXEMPTION**

Name of person insuring participant as a dependent : \_\_\_\_\_  
 Relation to participant : \_\_\_\_\_  
 Name of employer through which this person is insured : \_\_\_\_\_  
 Name of insurer : \_\_\_\_\_  
 Reason for requesting exemption : \_\_\_\_\_  
 Eligibility date : \_\_\_\_\_

**I hereby wish to opt out of participation in the following insurance plan(s):**

- Basic Health Insurance     Complementary Health Insurance (if specified in contract)     Dental Care Insurance (if specified in contract)

**as I have been insured since \_\_\_\_\_ as a participant or dependent under a group insurance contract containing similar benefits.**

**ENCLOSE A COPY OF YOUR INSURANCE CERTIFICATE FROM THE PREVIOUS INSURER SHOWING THE COVERAGE HELD**

**3 – TERMINATION OF EXEMPTION**

Name and date of birth of individual(s) to be insured : \_\_\_\_\_  
 (other than participant) : \_\_\_\_\_  
 Relation to participant : \_\_\_\_\_  
 Name of previous insurer : \_\_\_\_\_  
 Is it **IMPOSSIBLE** for you to remain covered with the previous insurer? :  Yes  No  
 If yes, for which insurance benefits? \_\_\_\_\_  
 Reason for termination of coverage with previous insurer : \_\_\_\_\_  
 Date of termination of coverage with previous insurer : \_\_\_\_\_

**ENCLOSE A COPY OF YOUR INSURANCE CERTIFICATE FROM THE PREVIOUS INSURER SHOWING THE COVERAGE HELD**

**4 – SIGNATURES**

"I understand that any acceptance of my application by La Capitale Insurance and Financial Services Inc. is subject to the provisions of the contract under which I am covered."

Signed at \_\_\_\_\_, on this \_\_\_\_\_ day of \_\_\_\_\_ 20 \_\_\_\_.

\_\_\_\_\_  
 Signature of participant

\_\_\_\_\_  
 Signature of witness (other than participant)

**5 – SIGNATURE OF EMPLOYER**

\_\_\_\_\_  
 Signature of employer

\_\_\_\_\_  
 Date