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GROUP NO.	EMPLOYER NO.	IDENTIFICATION NO.

**1 – PARTICIPANT’S IDENTIFICATION**

FAMILY NAME		FIRST NAME	
ADDRESS	NO.	STREET	APT.
			PHONE AT HOME ( )
CITY	POSTAL CODE		PHONE AT WORK ( )

**2 – CIVIL STATUS OF THE PARTICIPANT**

- Single
- Civil union since \_\_\_\_\_
- Common-law spouse since \_\_\_\_\_
- Divorced since \_\_\_\_\_
- Married since \_\_\_\_\_
- Separated since \_\_\_\_\_
- Widowed since \_\_\_\_\_

**3 – IDENTIFICATION OF THE DEPENDENT(S)**

Dependents	<u>First name</u>	<u>Family name</u>	<u>Date of birth (Year-Month-Day)</u>
Spouse	_____	_____	_____
Child(ren)	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

**4 –SIGNATURES**

I hereby state that the aforementioned information is complete, true and in conformity with the conditions and dispositions of my group insurance contract. Any false declaration may result in a cancellation of the insurance.

Signed in \_\_\_\_\_, on the \_\_\_\_\_ day of \_\_\_\_\_ 20 \_\_\_\_\_.

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

\_\_\_\_\_  
Signature of the witness (Different from the participant)

**Each employer may reprint this form for its needs.**