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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 ( )
CIVIL STATUS SINCE _____ <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> COMMON-LAW <input type="checkbox"/> CIVIL UNION <input type="checkbox"/> DIVORCED <input type="checkbox"/> SEPARATED <input type="checkbox"/> WIDOWED			

### 2 - IDENTIFICATION OF DEPENDENT

Family Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Gender:  M  F

Relationship with the participant: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Date of death: \_\_\_\_\_  
(Year-Month-Day) (Year-Month-Day)

Civil status since \_\_\_\_\_  CIVIL UNION  DIVORCED  MARRIED  SEPARATED  SINGLE  SINGLE PARENT  WIDOWED

### 3 - DECLARATION OF THE EMPLOYER

3.1 I declare that the above-mentioned **employee** is covered under the above-mentioned group insurance contract.

3.2 According to the group insurance contract, the above-mentioned **dependent** is covered for an amount of \$ \_\_\_\_\_.

3.3 Employment status of the employee:

Regular service  Temporary absence without remuneration since \_\_\_\_\_ to \_\_\_\_\_  
(Year-Month-Day) (Year-Month-Day)

Vacation from \_\_\_\_\_ to \_\_\_\_\_  Early retirement \_\_\_\_\_  
(Year-Month-Day) (Year-Month-Day)

Sick leave of absence since \_\_\_\_\_  Retirement \_\_\_\_\_  
(Year-Month-Day) (Year-Month-Day)

3.4 Death cause :  Accident  Illness

### 4 - DOCUMENTS TO SUPPLY

- 4.1 Join a photocopy of the most recent "T4" or "Relevé 1" or pay register.
- 4.3 Please, forward the claimant's name, address and phone number.

### 5 - SIGNATURE OF THE EMPLOYER

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

\_\_\_\_\_  
Signature