La Capitale
assurances et gestion du patrimoine

11203

EXEMPTION

❑ Application for exemption
❑ Termination of exemption

Delta II Building
2875 Laurier Blvd, Suite 100
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Québec QC G1K 8X9
Email: adm.collectif@lacapitale.com

Telephone: 418 644-4200
1 800 463-4856
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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):

4 Basic Health Insurance 4 Complementary Health Insurance (if specified in contract) 4 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? : 4 Yes 4 No
If yes, for which insurance benefits? ____________________

Reason for termination of coverage with previous insurer : ____________________

Date of termination of coverage with previous insurer : ____________________

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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

Employers may reproduce this form as their individual needs require.