



11108

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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.