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11201

MEMBERSHIP APPLICATION TO GROUP INSURANCE
(COMPLETE 1-2-4-5-6-7)

MODIFICATIONS TO GROUP INSURANCE
(COMPLETE 1-2-3-4-6-7 AND 5 IF NECESSARY)

ADVANTAGE 2-9

| | | |
|-----------|--------------|--------------------|
| GROUP NO. | EMPLOYER NO. | IDENTIFICATION NO. |
| | | |

1- INFORMATION RELATING TO PARTICIPANT

| | | | | |
|---|------------|--|---|---------------------------|
| NAME OF THE GROUP | | NAME OF THE EMPLOYER | | EMPLOYEE NO. |
| FAMILY NAME | FIRST NAME | GENDER <input type="checkbox"/> M <input type="checkbox"/> F | | DATE OF BIRTH Y M D |
| ADDRESS NO. STREET | | APT. | CORRESPONDENCE <input type="checkbox"/> E <input type="checkbox"/> F | |
| CITY | | POSTAL CODE | PHONE AT HOME () | |
| CIVIL STATUS <input type="checkbox"/> SINGLE OR <input type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> COMMON LAW SPOUSE <input type="checkbox"/> DIVORCED <input type="checkbox"/> SEPARATED <input type="checkbox"/> CIVIL UNION | | TIME WORK <input type="checkbox"/> FULL <input type="checkbox"/> PARTIAL : _____ (%) OR _____ (WKLY/HRS) | | |
| SINCE: Y M D | JOB TITLE | ANNUAL SALARY | EMPLOYMENT DATE Y M D | ELIGIBILITY DATE Y M D |
| STATUS <input type="checkbox"/> PERMANENT <input type="checkbox"/> OTHER (SPECIFY) : _____ | | | | |

2- COVERAGE(S)

MANDATORY COVERAGE FOR EMPLOYEES

BASIC HEALTH INSURANCE

- INDIVIDUAL COVERAGE
- FAMILY COVERAGE
- EXEMPTION**

BASIC LIFE INSURANCE

- INDIVIDUAL COVERAGE
- FAMILY COVERAGE

OPTIONAL COVERAGE FOR EMPLOYEES

ADDITIONAL HEALTH INSURANCE

- INDIVIDUAL COVERAGE
- FAMILY COVERAGE

PARTICIPANT'S OPTIONAL LIFE INSURANCE*:

FROM 1 TO 10 UNITS OF \$10,000 = _____ UNITS

YES

SPOUSE'S OPTIONAL LIFE INSURANCE*:

FROM 1 TO 10 UNITS OF \$10,000 = _____ UNITS

YES

OPTIONAL COVERAGE FOR EMPLOYERS (Mandatory if employer selected one or more of these options)

DENTAL CARE INSURANCE

- INDIVIDUAL COVERAGE
- FAMILY COVERAGE
- EXEMPTION**

SHORT-TERM DISABILITY INSURANCE*

YES

LONG-TERM DISABILITY INSURANCE*

YES

IMPORTANT: * FILL OUT THE EVIDENCE OF INSURABILITY FORM

** TO BE EXEMPTED FOR HEALTH OR DENTAL CARE INSURANCE, THE EMPLOYEE MUST PROVE TO HIS EMPLOYER THAT HE OR SHE IS COVERED UNDER ANOTHER PLAN OFFERING SIMILAR BENEFITS.

DIRECT DEPOSIT SERVICE FOR REIMBURSEMENT OF HEALTHCARE EXPENSES

I would like to take advantage of the free Direct Deposit service and I authorize La Capitale Insurance and Financial Services Inc. to deposit my Health Insurance and/or Dental Care Insurance benefits in my bank account. (Please enclose a cheque specimen marked "Void").

3- MODIFICATIONS

| | |
|---|---|
| REASON(S) | EFFECTIVE DATE Y M D |
| PLEASE : LEAVE OF ABSENCE, PARENTAL LEAVE, MATERNITY, TEMPORARY LAY OFF, BIRTH, MARRIAGE, DISABILITY, ETC. | |
| A) <input type="checkbox"/> MODIFY MY GROUP INSURANCE COVERAGE(S) CHECK (✓) AGAIN ALL COVERAGES CHOSEN (PART 2) | DATE OF RETURN (IF APPLICABLE) Y M D |
| B) <input type="checkbox"/> RETAIN ALL COVERAGES IN MY GROUP INSURANCE | |
| C) <input type="checkbox"/> CANCEL ALL COVERAGES IN MY GROUP INSURANCE EXCEPT DRUG INSURANCE COVERAGE | |

4- IDENTIFY YOUR DEPENDENTS

| | | | | | | | | |
|--------------------|-------------|---|------------------------|--------------|------------|-------------|---|------------------------|
| First name | Family name | Gender | Date of birth Y M D | Children(s): | First name | Family name | Gender | Date of birth Y M D |
| Spouse: _____ | _____ | <input type="checkbox"/> M <input type="checkbox"/> F | _____ | _____ | _____ | _____ | <input type="checkbox"/> M <input type="checkbox"/> F | _____ |
| Children(s): _____ | _____ | <input type="checkbox"/> M <input type="checkbox"/> F | _____ | _____ | _____ | _____ | <input type="checkbox"/> M <input type="checkbox"/> F | _____ |
| _____ | _____ | <input type="checkbox"/> M <input type="checkbox"/> F | _____ | _____ | _____ | _____ | <input type="checkbox"/> M <input type="checkbox"/> F | _____ |

5- BENEFICIARY'S FULL NAME (FOR LIFE INSURANCE COVERAGES)

ATTENTION: THE DESIGNATION OF AN IRREVOCABLE BENEFICIARY INVOLVES SIGNIFICANT CONSEQUENCES. HIS CONSENT WILL BE ABSOLUTELY NECESSARY IF YOU WANT TO REPLACE HIM AND, IF A MINOR, THE CONSENT OF HIS TUTOR WILL HAVE TO BE OBTAINED.

DESIGNATION: _____ MARK YOUR CHOICE REVOCABLE IRREVOCABLE

RELATIONSHIP WITH THE PARTICIPANT: _____

6- DECLARATION OF THE PARTICIPANT

«I hereby authorize my employer to deduct the required premiums from my salary, La Capitale Insurance and Financial Services Inc. (hereinafter mentioned La Capitale) and the person responsible for the plan to use my social insurance number for identification and administration. Furthermore, I authorize any physician, any other professional and intervening party in the field of health and rehabilitation, as well as any public or private health or social services institution, any insurance company, as well as any reinsurer, any public or private organization, any information agency that will have received such a mandate, any market intermediary, any employer or ex-employer, the policyholder as well as any person holding personal files or information, especially medical records pertaining to me, as the case may be, to provide to La Capitale or to its mandataries, any information that it holds, required for the processing of my file.

I also authorize La Capitale to transmit such information to the aforementioned persons when necessary, within the scope of its activities and the processing of my file.

In the event of death, I specifically authorize the policyholder, the employer, the beneficiary, the heir or the liquidator of my succession to provide La Capitale or its mandataries when necessary, with all information or authorizations permitting the processing of my file.»

This consent is valid for the purposes of this contract, its amendment, extension or renewal. A photocopy of this consent has the same value as the original.

Signature of the participant or, if under age, that of his or her legal representative () - Phone number - Date

(PLEASE CONSULT THE NOTICE ON THE BACK)

7- SIGNATURE OF THE EMPLOYER

() - Phone number - Date