La Capitale Civil Service Insurer Inc.
625 Jacques-Parizeau St, PO Box 1500, Quebec QC G1K 8X9
418 644-4200 or 1 800 463-4856

NOTICE

☐ **Temporary work interruption**
☐ **Return to work**

Group No.	Employer No.	Identification No.
0 0 0 1 1 0 0 1 8 0		

1. INFORMATION ABOUT PARTICIPANT

Last name	First name	Date of birth (YYYY/MM/DD)

No., Street, Apt.	City

Province	Postal code	Main phone	Ext.	Phone (other)	Ext.

2. TERMINATION OF PAYMENT

Please check the reason below	Start date of leave or date of event (YYYY/MM/DD)	Date of return to work (YYYY/MM/DD)
☐ Disability Insurance		
☐ Dismissal contested by grievance[1]		
☐ End of contract[2]		
☐ Leave without pay[1]		
☐ Temporary layoff[1]		
☐ Suspension[1]		
☐ Other: _____		

Note 1: Coverage for all benefits may be maintained with payment of the premium, including the employer's share, if applicable. | **Note 2:** I do not wish to keep my benefits during the two months following the end date, as provided for in the contract. If the participant keeps his or her benefits, the end of the contract must be sent to the Insurer using the usual *Notice of change* form.

3. PARTICIPANTS DECLARATION

I hereby declare that I wish to:

☐ Maintain my group insurance benefits
☐ Cancel only the benefits from the following coverage:
  ☐ Life Insurance ☐ Disability Insurance
☐ Cancel all my group insurance benefits, except from the Health Insurance Plan and Dental Care coverage.

4. PARTICIPANT'S SIGNATURE

I hereby agree to reimburse the required premium directly to the employer using the following method: _____

Signature _____ Date (YYYY/MM/DD) _____

IMPORTANT : If neither of the boxes in the previous section is marked or if this form is unsigned, the participant's benefits will be suspended from the start date of the absence, with the exception of Health and Dental Care Insurance (3rd choice). The participant has 30 days following the start date to restore coverage under these benefits. To do so, he or she must send this form to the Insurer, duly completed and signed, within the 30 days period. In such case, premiums are payable as of the start date of absence.

5. SIGNATURE EMPLOYER'S REPRESENTATIVE

Signature _____ Date (YYYY/MM/DD) _____

This form may be sent to the Insurer by mail, fax or email, using the above contact information.
If you do not send the original document, make sure you store it in a safe place.
Please note that the Insurer may require the original document at any time for audit purposes.