

Policy No. 0 0 3 9 9 2	Reserved for La Capitale Identification No.
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1. INFORMATION ABOUT THE POLICYHOLDER

Last name		First name		Date of birth Year Month Day		
Gender <input type="checkbox"/> M <input type="checkbox"/> F	Language: <input type="checkbox"/> English <input type="checkbox"/> French	No., street, apt.		City		
Province	Postal code	Main phone	Ext.	Phone (Other)	Ext.	
Email address ¹				Note 1: By giving my email address, I consent to receiving only documents that pertain to my insurance policy.		
Civil status <input type="checkbox"/> Single <input type="checkbox"/> Married or civilly united ² <input type="checkbox"/> Common-law spouse ² <input type="checkbox"/> Widowed ² <input type="checkbox"/> Divorced ² <input type="checkbox"/> Separated ²				Note 2: Since Year Month Day		

2. INFORMATION ABOUT THE PREVIOUS CONTRACT OR CURRENT CONVERSION PRODUCT

I am or was insured under a group health insurance plan.

Contract No.: _____ Insurer: _____

Identification No., if insured by La Capitale: _____ Contract termination date: _____
 Year Month Day

If your insurer was not La Capitale Civil Service Insurer Inc. (La Capitale), attach a document that demonstrates you were covered by a group health insurance plan and also includes the contract termination date and the name of each insured. If you submit your application more than 60 days after the contract termination date, please complete the Declaration of Insurability form and attach it to this form.

I am **currently** insured under an individual health insurance conversion product, including travel insurance for a minimum period of 30 days, obtained when the group insurance plan terminated. Attach proof of coverage that was in force within the last 60 days.

Product name: _____ Insurer: _____

Insurance will take effect 30 days after this form is signed or, if evidence of insurability is required, on the date such evidence is approved.

3. CHOICE OF COVERAGE, PLAN AND OPTIONAL COVERAGE SUPPLEMENT

				I want to apply	I want to remove
Minimum participation period ³		Single plan selection	Single coverage status selection		
Basic Plan:	24 months	<input type="checkbox"/> Basic Plan	– Individual	<input type="checkbox"/>	<input type="checkbox"/>
Intermediate and Enriched Plan:	36 months	<input type="checkbox"/> Intermediate Plan	– Single-Parent	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/> Enriched Plan	– Family ⁴	<input type="checkbox"/>	<input type="checkbox"/>
OPTIONAL COVERAGE SUPPLEMENT⁵ (minimum participation period: 24 months)				<input type="checkbox"/>	<input type="checkbox"/>

Note 3: The policyholder must maintain the selected plan for the minimum period of participation indicated below. This period begins on the effective date of the plan, and it will not be possible to make changes until January 1 following the minimum participation period. However, certain life events may allow a policyholder to review his or her plan regardless of the minimum period. | **Note 4:** If dependents are or were insured under a contract other than the one indicated in Section 2, attach proof of coverage held if it ended within the last 30 days. If dependents were not insured under any contracts indicated in Section 2 or if they were insured under an insurance contract that terminated more than 30 days ago, they must complete the Declaration of Insurability form and attach it to this form. | **Note 5:** At the time of your plan selection, you can also enrol in the optional coverage supplement. The coverages under the optional coverage supplement, which cannot be purchased separately, are added to the selected plan (Basic, Intermediate or Enriched), under the same coverage status (Individual, Family or Single-Parent).

DIRECT DEPOSIT SERVICE FOR REIMBURSEMENT OF HEALTHCARE EXPENSES

I authorize La Capitale to deposit my health insurance and/or dental care insurance benefits in my bank account. (Please complete the following bank information; no cheque specimen is required).

Branch No.	Institution No.	Account No.
_____	_____	_____

4. REASONS FOR MODIFICATION

Birth or adoption of a child, separation or divorce, death of the spouse or a dependent, termination of eligibility of the last dependent child, termination of the minimum participation period, etc.

Effective date of the event: _____
 Year Month Day

