La Capitale Civil Service Insurer Inc.
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☐ **GROUP INSURANCE APPLICATION**
☐ **MODIFICATION TO GROUP INSURANCE**
☐ **REGISTRATION IN THE GROUP ADMINISTRATOR'S CENTRE**

Group No.	Employer No.	Identification No. (provided by the Insurer at the time of application)
0 0 6 0 0 0		

1. INFORMATION ABOUT PARTICIPANT

Group name	Employer name	Employee No. or ID
FTQ INTERSECTORIAL PARITY COMMITTEE		

First name	Last name	Date of birth (YYYY/MM/DD)	Gender	Language
			☐ F ☐ M	☐ French ☐ English

No., street, apt.	City	Province	Postal code

Email address[1]	Main phone Ext.	Phone (other) Ext.

Note 1: By giving my email address, I consent to receiving only documents that concern my group insurance..

Civil status: ☐ Single ☐ Married or civil union ☐ Common-law spouse ☐ Widowed ☐ Divorced ☐ Separated — Since (YYYY/MM/DD)

Employment date (YYYY/MM/DD)	Eligibility date (YYYY/MM/DD0	Employment status
		☐ Permanent ☐ Temporary ☐ Other: ____________

Job title	Annual salary (full-time)	Work arrangement
	$ ____________	☐ Full-time ☐ Part-time: ________% ou ______ hours/weeks

2. REASON FOR MODIFICATION

Reason: ________________________________ Effective date of the event:
Obtaining a position for the first time, marriage, divorce, parental leave, adoption, birth, death, etc.

I wish to:
☐ modify my group insurance plans
☐ maintain all my group insurance plans
☐ cancel all my group insurance plans, except for my basic health insurance plan

Planned date of return to work (if applicable):

3. PLANS[2]

Basic Health Insurance Plan - Mandatory

For complete tier, the minimum participation requirement is **36 months.**

Tier selection
☐ Complete tier
☐ Reduced tier
☐ Exemption[3]

Participant status
☐ Individual
☐ Single-Parent (no spouse)
☐ Family

	I want to apply	I want to add	I want to remove
Optional Plan			
☐ **Option I – Extended Health Insurance Plan** ☐ **Option II – Dental Care Insurance Plan[4]** **Participant status:** ☐ Individual ☐ Single-Parent (no spouse) ☐ Family[5] For each option, the minimum participation requirement is **36 months.**	☐	☐	☐
Option III – Optional Life Insurance Plan[4]			
Participant's Basic Life Insurance[6] – 1 times the annual salary	☐	☐	☐
Participant's Accidental Death and Dismemberment Insurance – 1 times the annual salary	☐	☐	☐
Participant's Spouse's and Dependent Children's Life Insurance[7] – Spouse: $5,000 – Dependent child: $2,500	☐	☐	☐
Optional Life Insurance[8] – Participant: 1 to 5 times the annual salary ☐ Smoker ☐ Non-smoker – Spouse: 1 to 20 units of $5,000 ☐ Smoker ☐ Non-smoker	____ x salary ____ unit(s)	____ x salary ____ unit(s)	____ x salary ____ unit(s)

Note 2: The participant's premiums are payable to the Insurer, even if there is no pay during the period. The Insurer may cancel the coverages within 30 days following the expiration of all unpaid premiums. | **Note 3:** To take advantage of the exemption entitlement, participants must provide the employer with proof that they and their dependents, if any, are covered under another group insurance plan offering similar benefits. | **Note 4:** If this benefit is added while insurance is in force, evidence of insurability is required at all times. Please complete the *Declaration of Insurability – Dental Care Insurance plan* form, if required. | **Note 5:** To be eligible for Family or Single-Parent coverage status under Option I or Option II, participant must have the same status under Basic Life Insurance plan, unless he is exempted. | **Note 6:** Participation in this benefit is mandatory in order to be eligible for the other Life Insurance benefits. | **Note 7:** Participation in this benefit is mandatory in order to be eligible for Spouse's Optional Life Insurance. | **Note 8:** To enroll in this benefit, evidence of insurability is required at all times. Please complete the *Declaration of insurability* form.

☐ 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).

⑈243⑈ ⑆00005⑉123⑆ 12345⑉123456⑈

Branch No. Institution No. Account No.

Branch No. Institution No. Account No.

4. INFORMATION ABOUT DEPENDENTS

	Full name	Gender F M	Date of birth (YYYY/MM/DD)	Dependent child with a functional impairment[9]	Fill this out for a dependent child age 18 or over, who is a full-time student[10]	
					Start date of school year (YYYY/MM/DD)	End date of school year (YYYY/MM/DD)
Spouse		☐ ☐				
Children		☐ ☐		☐		
		☐ ☐		☐		
		☐ ☐		☐		
		☐ ☐		☐		

Note 9: Please contact customer service for how to proceed.
Note 10: La Capitale reserves the right to ask you for written proof from the institution attended at any time.

5. WITHDRAWAL OF DEPENDENTS

Please fill in Section 3 if you wish to change you coverage and indicate the reason for modification in Section 2.

Full name	Full name

6. BENEFICIARY DESIGNATION (for Option III – Optional Life Insurance Plan)

Revocable	Irrevocable	Full name	Percentage	Relationship to participant
☐	☐			
☐	☐			
☐	☐			

IMPORTANT NOTICE: If percentages are indicated, they must add up to 100%. If percentages are not specified, the Life Insurance benefit will be equally shared among the designated beneficiaries. **PROVINCE OF QUEBEC:** Designating a legally married or civilly united spouse as a beneficiary is considered irrevocable unless stipulated otherwise by the participant. Any irrevocable beneficiary designation may only be modified if the beneficiary is of legal age and signs a waiver of his or her right as a beneficiary. **PROVINCES OTHER THAN QUEBEC:** A beneficiary designation is considered revocable unless stipulated otherwise by the participant. Any irrevocable beneficiary may only be modified if the beneficiary is of legal age and provides written consent to the change.

7. DESIGNATION OF A TRUSTEE (does not apply in Quebec)

If you designate a beneficiary who has not reached the age of majority, you must name a trustee.

Full name			
No., street, apt.	City	Province	Postal Code

8. SIGNATURE OF EMPLOYER'S REPRESENTATIVE

X ______________________ Date: Year Month Day Phone

Signature

9. PARTICIPANT'S AUTHORIZATION

"**I hereby authorize** my employer to deduct the required premiums from my salary and **authorize** La Capitale and the plan administrator to use my social insurance number for administration purposes. Furthermore, **I authorize** any physician, any other professional and any intervening party in the field of health and rehabilitation, as well as any public or private health and social services institution, any insurance company, as well as any reinsurer, any public or private organization, any information agency, any market intermediary, any employer or ex-employer, the policyholder as well as any person holding personal files or information, particularly medical records, pertaining to me to provide to La Capitale or its service providers, any information that may be required for the processing of my file. This authorization is also valid, in the event of my death, with regard to any person or organization holding information required by La Capitale, or its service providers, that may be 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."

This authorization is valid for the purposes of this contract and for any amendments, extensions or renewals. A photocopy of this authorization is considered as valid as the original.

X ______________________ Date: __________

Participant's signature of, if a minor, signature of legal guardian YYYY/MM/DD

10. NOTICE

La Capitale wishes to advise you that the information collected will be kept in a file under the subject "Group Insurance". Notwithstanding exceptions provided for by law, access to this file is restricted to employees, service providers of the company, on a need-to-know basis, as required to fulfill their duties or carry out their assignments. Your file will be kept at the address below.

You may access your file or request correction of an inaccurate or incomplete information by submitting a written request to the Information Access Officer at the Administration Department.

To serve its customers, La Capitale Financial Group Inc., its subsidiaries and authorized representatives may use your personal information (name, address, phone number and email address) to inform you of products and services that may be of interest to you. If, however, you do not wish to receive this information, please write us at the address below.

To contact our Customer Service:

Telephone: 418 644-4200
Toll free: 1 800 463-4856
Email: adm.collectif@lacapitale.com

La Capitale Civil Service Insurer Inc.
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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.