

La Capitale Civil Service Insurer Inc.  
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- GROUP INSURANCE APPLICATION  
 MODIFICATION TO GROUP INSURANCE

Group No. <b>0   0   6   0   0   0</b>	Employer No. 	Identification No. 
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### 1. INFORMATION ABOUT RETIREE PARTICIPANT

Group name <b>CPI-FTQ (RETIREE)</b>		Employer's name before retirement				
First name		Last name		Date of birth (YYYY/MM/DD) 	Gender <input type="checkbox"/> F <input type="checkbox"/> M	Language <input type="checkbox"/> French <input type="checkbox"/> English
No., street, apt.			City		Province	Postal Code 
Main phone 	Ext. 	Phone (other) 		Annual salary before retirement \$ _____	Retirement date (YYYY/MM/DD) 	
Email address <sup>1</sup>						

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

Civil status						Since (YYYY/MM/DD) 
<input type="checkbox"/> single	<input type="checkbox"/> married or civil union	<input type="checkbox"/> common-law spouse	<input type="checkbox"/> widowed	<input type="checkbox"/> divorced	<input type="checkbox"/> separated	

### 2. REASON FOR MODIFICATION

Reason: \_\_\_\_\_ Effective date of the event: | | | | | | | |

### 3. COVERAGES<sup>2</sup>

As a retiree, you have the possibility to maintain or to decrease you Group Life Insurance coverage:

	I want to apply	I want to remove
<b>Basic Life Insurance<sup>3 and 4</sup></b> 1 to 20 units of \$5,000	_____ units	_____ units
<b>Dependent's Life Insurance<sup>5</sup></b> Spouse: \$5,000      Dependent children <sup>6</sup> : \$2,500	<input type="checkbox"/>	<input type="checkbox"/>
<b>Spouse's Additional Life Insurance<sup>7</sup></b> 1 to 20 units of \$5,000	_____ units	_____ units

**Note 2:** To enroll in any retiree's Life Insurance coverage, you must notify the Insurer within 31 days following your retirement date or upon reception of this application form. Following the expiry of this period, it won't be possible for the retiree to enroll in these coverages. | **Note 3:** Participation in this coverage is mandatory to enroll in other Life Insurance coverages. | **Note 4:** The chosen amount must not exceed the amount held just before retirement for all Participant's Life Insurance coverages. | **Note 5:** Participation in this coverage is mandatory to enroll in Spouse's Additional Life Insurance. | **Note 6:** From the age of 24 hours. | **Note 7:** Retiree participant can keep in force, in whole or in part, the coverage held under Spouse's Optional Life immediately before retirement, without exceeding it.

### 4. INFORMATION ABOUT DEPENDENTS

	Full name	Gender F M	Date of birth (YYYY/MM/DD)	Dependent child with a functional impairment <sup>8</sup>	Fill this out for a dependent child age 18 or over, who is a full-time student <sup>9</sup>	
					Start date of school year (YYYY/MM/DD)	End date of school year (YYYY/MM/DD)
Spouse		<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/>		
Children		<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/>		
		<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/>		
		<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/>		

**Note 8:** Please contact customer service for how to proceed.

**Note 9:** La Capitale reserves the right to ask you for written proof from the institution attended at any time.

### 5. BENEFICIARY DESIGNATION (for Life Insurance coverages)

Revocable	Irrevocable	Full name	Percentage	Relationship to participant
<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/>	<input type="checkbox"/>			

**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.

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

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

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

## 7. METHOD OF PREMIUM PAYMENT

- Preauthorized Debit Agreement (PAD) – Personal** (Please attach a cheque specimen if this method of payment is retained)  
**Debit characteristics** – This is a variable amount PAD. You, as the payor, authorize La Capitale to debit from the bank account indicated the amounts required for payment of the premium plus taxes and any charges applicable to your insurance policy. Your preauthorized payment frequency will correspond to your billing frequency. The preauthorized payment will take place 15 days following the production of your invoice. You also authorize La Capitale to carry out a redraw within 10 days in the event that a preauthorized payment does not clear the account. In such case, an administration fee may be applied.

**Waiver** – I hereby waive the right to be notified regarding:

- 1) Authorization before the first payment if processed;
- 2) Subsequent payments, and
- 3) Changes to the amount or date of the preauthorized payment initiated by me or by the company.

**Cancellation** – I may revoke my authorization by providing 30 days' notice. To obtain a sample PAD cancellation form, or for more information about my right to cancel a PAD, I may contact my financial institution or visit [www.payments.ca](http://www.payments.ca). I understand that the Insurer may terminate this agreement by providing 30 days' written notice.

**Recourse and reimbursement** – I agree to contact La Capitale in the event that a PAD is disputed.

You have certain recourse rights if any debit does not comply with this agreement. For example, you have the right to receive reimbursement for any debit that is not authorized or is not consistent with this PAD. To obtain information on your recourse rights, you may contact your financial institution or visit [www.payments.ca](http://www.payments.ca).

  X   \_\_\_\_\_ Date: \_\_\_\_\_  
Signature of account holder YYYY/MM/DD

  X   \_\_\_\_\_ Date: \_\_\_\_\_  
Signature of second account holder, if required YYYY/MM/DD

- Retraite Québec**  
If you are a retired Quebec public or parapublic sector employee, the payment may be debited from your pension benefits. As the recipient of benefits from *Retraite Québec*, I authorize this organization to deduct the required contributions from my pension cheque until I give notice otherwise.

  X   \_\_\_\_\_ Date: \_\_\_\_\_ 

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Signature of contribution YYYY/MM/DD Social Insurance No. (SIN) (mandatory for enrolling in this method of payment)

## 8. RETIREE PARTICIPANT'S AUTHORIZATION

"I **hereby authorize** La Capitale Civil Service Insurer Inc. (La Capitale) to use my social insurance number for 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, any market intermediary, any employer or ex-employer, 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 service providers, any information required for the processing of my file.

I **also authorize** 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 beneficiary, the heir or the liquidator of my estate to provide to La Capitale, or its mandataries and agents, upon request, any information it may hold that may be required for the processing of my file."

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

  X   \_\_\_\_\_ Date: \_\_\_\_\_  
Retiree participant signature YYYY/MM/DD

## 9. 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.

<b>To contact our Customer Service</b>	Telephone:	418 644-4200	La Capitale Civil Service Insurer Inc.
	Toll free:	1 800 463-4856	625 Jacques-Parizeau St, PO Box 1500
	Email:	<a href="mailto:adm.collectif@lacapitale.com">adm.collectif@lacapitale.com</a>	Quebec QC G1K 8X9 • <a href="http://lacapitale.com">lacapitale.com</a>

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.