La Capitale

TERMINATION OF EXEMPTION

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 • Fax: 418 646-1313 • adm.collectif@lacapitale.com

Group No.	Employer No.	Identification No.
0 0 6 0 0 0		

1. INFORMATION ABOUT PARTICIPANT

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

No., street, apt.	City	Postal code

Province	Main phone	Ext.	Phone (other)	Ext.	Employment date (YYYY/MM/DD)

2. PREVIOUS INSURER

IMPORTANT: Applications must be submitted within 30 days following the event.

Name of previous insurer: ______________________________

Is it possible for you to remain insured by the previous insurer? ☐ Yes ☐ No

Reason for termination of coverage with the previous insurer: ______________________________

Date of last day of coverage by the previous insurer: ______________________________

Coverage(s) held with the previous insurer: ☐ Basic Health ☐ Extended Health ☐ Dental Care

3. I WOULD LIKE TO ENROL IN THE FOLLOWING GROUP INSURANCE PLANS:

Basic Health Insurance		Optional Plan I (Extended Health)	Optional Plan 2 (Dental Care)
☐ Complete tier (mandatory participation: **36 months**)	☐ Individual	☐ Individual	☐ Individual
☐ Reduced tier	☐ Single-Parent	☐ Single-Parent	☐ Single-Parent
	☐ Family	☐ Family	☐ Family

IMPORTANT: To be eligible for Family or Single-Parent coverage status under Optional Plans 1 or 2, you must have the same coverage status under the Basic Health Insurance plan. The 36-month minimum participation period applies to the optional plans for participants and their eligible dependents.

4. INFORMATION ABOUT DEPENDENTS

	Full name	Sex F M	Date of birth (YYYY/MM/DD)	Dependent child with a functional impairment[1]	Complete this for a dependent child age 18 or over, who is a full-time student[2]: Start date of the semester (YYYY/MM/DD)	End date of the semester (YYYY/MM/DD)
Spouse		☐ ☐				
Children		☐ ☐		☐		
		☐ ☐		☐		
		☐ ☐		☐		
		☐ ☐		☐		

Note 1: Please contact customer service for how to proceed.
Note 2: La Capitale reserves the right to ask you for written proof of attendance from the institution at any time.

5. SIGNATURE OF PARTICIPANT

I declare that the information provided above is complete, true and in conformity with the terms and provisions of my group insurance contract. Any false declaration may result in the cancellation of the insurance.

I understand that my request for termination of exemption is conditional on approval by La Capitale Civil Service Insurer Inc., in accordance with the provisions of the contract under which I am covered.

Signed at ______________________________, on this __________ day of ____________________ 20 ________.

____
Signature of participant

6. SIGNATURE OF EMPLOYER'S REPRESENTATIVE

______________________________ ____________________
Signature of representative Date

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, store it in a safe place.
Please note that the Insurer may require the original document at any time for audit purposes.