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 INSURANCE APPLICATION**
☐ **MODIFICATION(S) TO GROUP INSURANCE**

Group No.	Employer No.	Identification No. (provided by the Insurer at the time of enrolment)
0 0 9 9 9 5		

1. INFORMATION ABOUT PARTICIPANT

Group name	Employer name	Employee no. or ID
FÉDÉRATION AUTONOME DE L'ENSEIGNEMENT (teachers)		

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

No., street, apt.	City	Province	Postal code

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

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

Civil status — As of (YYYY/MM/DD)

☐ Single ☐ Married or civilly united ☐ Common-law ☐ Widowed ☐ Divorced ☐ Separated

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

Job title	Annual salary	Work schedule
		☐ Full-time ☐ Part-time: _____ % or _____ hours/week

2. REASON FOR MODIFICATION (Please check the insurance coverages set out in the contract)

_____ _____
Leave without pay, parental or maternity leave, temporary layoff, birth, marriage, etc.

Effective date of the event: _____ (YYYY/MM/DD) Planned date of return to work (if applicable): _____ (YYYY/MM/DD)

☐ Change my group insurance benefits (check all desired benefits again in Section 3).
☐ Maintain all my group insurance benefits.
☐ Cancel all my group insurance benefits except for my health insurance plan (including prescription drug insurance).

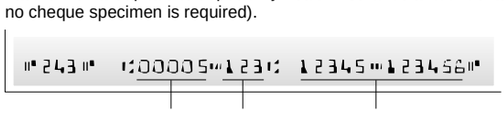
3. COVERAGES

	I want to apply	I want to remove
MANDATORY PLAN		
▪ **Health Insurance** **Minimum participation requirement** Health Plan 2: 12 months Health Plan 3: 24 months **Single module selection** ☐ Health Plan 1 ☐ Health Plan 2 ☐ Health Plan 3 **Coverage status selection** - Individual - Single-parent (no spouse) - Family - Exempt[2] ☐	☐ ☐ ☐	☐ ☐ ☐
▪ **Long-Term Disability Insurance[3]** **Important :** If you are a rehired retiree, it may be to your advantage to be exempt from coverage under the Long-Term Disability Insurance plan (see Note 3).	☐	
▪ **Short-Term Disability Insurance (if provided under the contract)**	☐	
LIFE INSURANCE OPTIONAL PLAN		
▪ **Participant's Life Insurance[4] :** – Mandatory basic amount: : $10,000[5] ☐ I exercice my right to opt[7] when applying for the participant's mandatory life insurance amount of $10,000. – Optional amounts: $10,000, $25,000, $50,000, $75,000, $100,000, $125,000, $150,000, $175,000, $200,000, $225,000 or $250,000[7] – Smoking status: ☐ smoker ☐ non-smoker	_____ $	_____ $
▪ **Dependents' Life Insurance** – Spouse: $10,000 – Dependent child: $5,000[8]	☐	☐
▪ **Spouse's Optional Life Insurance[9]** – to 10 unit(s) of $10,000 Number of units: – Smoking status: ☐ smoker ☐ non-smoker	_____	_____

Note 2: To be exempt from coverage under the Health Insurance plan, participants must provide the employer with proof of insurance under a group insurance plan with similar benefits. | **Note 3:** To be exempt from coverage under the Long-Term Disability Insurance plan, participants must complete the Exemption from Long-Term Disability Insurance form and meet the conditions set out in the form. | **Note 4:** The first $10,000 is automatically granted without evidence of insurability. The amounts of $25,000 and $50,000 are also available without evidence of insurability during the first 30 days after the eligibility date. After such time, and for all other amounts of coverage, evidence of insurability is required. Please complete the Declaration of Insurability form. | **Note 5:** Declaration of insurability form must be duly completed and signed to add the mandatory basic amount while insurance is in force. | **Note 6:** Participant may exercice the right to opt out within 90 days. If the participant exercice his right to opt out, no additional amount of Participant's Life Insurance can be granted. | **Note 7:** Optional amounts does not add up to the basic amount of $10,000, this mandatory basic amount is already included in the optional amounts. Furthermore, from the date of the participant's 65th birthday, amounts in excess of $25,000 are reduced by 50%. | **Note 8:** In the case of Single-Parent coverage status, the insured amount is increased by an amount of $10,000 divided by the number of dependent children in the family. | **Note 9:** Dependent's Life Insurance is mandatory to enrol in this benefit. Declaration of insurability must be duly completed and signed.

☐ 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.

Branch No. Institution No. Account No.

4. INFORMATION ABOUT DEPENDENTS

	Full name	Sex F M	Date of birth (YYYY/MM/DD)	Child with a functional impairment[10]	Fill this out for a dependent child age 18 or over, who is a full-time student[11]	
					Start date of the semester (YYYY/MM/DD)	End date of the semester (YYYY/MM/DD)
Spouse		☐ ☐				
Children		☐ ☐		☐		
		☐ ☐		☐		
		☐ ☐		☐		
		☐ ☐		☐		
		☐ ☐		☐		

Note 10: Please contact customer service for how to proceed. | **Note 11:** La Capitale reserves the right to ask you for written proof of attendance from the institution.

5. WITHDRAWAL OF DEPENDENTS' COVERAGE

Please fill in Section 3 if you wish to change your group insurance benefits and indicate the reason for modification in Section 2.

Full name	Full name

6. BENEFICIARY DESIGNATION (for Life Insurance coverage)

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

IMPORTANT NOTICE: If percentages are indicated, they must add up to a maximum of 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 designation may only be modified if the beneficiary is of legal age and provides written consent to the change.

7. TRUSTEE DESIGNATION FOR A MINOR BENEFICIARY (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. PARTICIPANT'S AUTHORIZATION

I hereby agree to the provisions of the policy and **consent** to the required premiums being deducted from my salary, as applicable.

I agree to my social insurance number being used for administrative purposes by La Capitale Civil Service Insurer Inc. (La Capitale).

I **authorize** my employer, the policyholder, La Capitale or its reinsurers as well as its representatives, agents and mandataries to provide, receive and exchange any personal information regarding my eligibility, insurability and claims for benefits under the plan and those of my dependents, if applicable. In the event of death, I **specifically authorize** the policyholder, the employer, 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 authorization shall be valid for the purposes of this contract and for any amendments, extensions or renewals thereof. A photocopy of this authorization shall be considered as valid as the original if used for the exchange of information.

X _____ Date: _____ _____

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

9. SIGNATURE OF EMPLOYER'S REPRESENTATIVE

X _____ Date: _____ _____

Signature — YYYY/MM/DD — Telephone

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 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.
625 Jacques-Parizeau St, PO Box 1500
Quebec QC G1K 8X9 | lacapitale.com

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.