WAIVER OF LONG-TERM DISABILITY INSURANCE

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

Group No.	Employer No.	Identification No.
0 0 9 9 9 5		

1. ABOUT PARTICIPANT

First name	Last name	Date of birth (YYYY-MM-DD)

No., street, apt.	City

Province	Postal code	Main phone	Ext.	Phone (other)	Ext.

2. WAIVER

I, the undersigned, no longer with to participate in the mandatory Long-Term Disability Insurance benefit, as I meet one of the following criteria:

- ☐ I am retiree and I receive a Retirement pension.
- ☐ I participate in the Government and Public Employees Retirement Plan (RREGOP) and have accumulated 33 years of service, or more.
- ☐ I am age 53 or over.
- ☐ I am a member of a professional order and am covered under a similar benefit of Long-Term Disability Insurance plan provided by the order.
  Please enclose proof that such insurance is in force, along with a copy of the policy or insurance booklet.
- ☐ I have signed a retirement agreement, without the option of returning, and there are two years of less between the date of waiver and the date of retirement.
  Please enclose a copy of the agreement.

It is understood that La Capitale Civil Service Insurer Inc. shall terminate my Long-Term Disability Insurance plan on the first pay period following the reception of this document.

As such, **I will have no recourse** against my employer or La Capitale Civil Service Insurer Inc. with regard to any claim whatsoever. Furthermore, **I understand** that in no case may I obtain coverage under this benefit in the future, even if I provide evidence of insurability.

IMPORTANT: Even if you are eligible, maintaining this benefit may be to your advantage. In order to make an informed choice, it is recommended that you contact your union representative.

3. PARTICIPANT'S DECLARATION

I hereby state that the aforementioned information is complete and true. Any false declaration may result in a cancellation of the insurance.

Signed in _____, on this _____ day of _____ 20 _____.

Participant's signature _____

4. SIGNATURE OF EMPLOYER'S REPRESENTATIVE

Signed in _____, on this _____ day of _____ 20 _____.

Signature _____

Please keep a copy for your records and return the original to the Insurer.