La Capitale Civil Service Insurer Inc.
Insurer and Financial Services Firm
625Jacques-Parizeau St, PO Box 1500, Quebec QC G1K 8X9
418 644-4200 or 1 800 463-4856

☐ GROUP INSURANCE APPLICATION
☐ MODIFICATION(S) TO GROUP INSURANCE
☐ SURVIVING SPOUSE
☐ ASSOCIATE MEMBER

RETURN THIS FORM TO:
AREF – Secretariat
PO Box 34009, Quebec QC G1G 6P2
1 888 513-2494 – aref-neq.ca – secretariat@aref-neq.ca

1. INFORMATION REGARDING INSURANCE FILE

Group No.	AREF Member No. – **Reserved for the use of AREF**	La Capitale Identification No.

Group's name
ASSOCIATION DES RETRAITÉES ET RETRAITÉS DE L'ENSEIGNEMENT DE LA FNEEQ (AREF)

Information at the time of retirement

Employer No.	Employer's name	Retirement date (Year / Month / Day)	Annual salary before retirement

2. INFORMATION ABOUT PARTICIPANT

Last name	First name	Date of birth (Year / Month / Day)

Gender ☐ M ☐ F	Language: ☐ French ☐ English	No., street, apt.	City

Province	Zip code	Main phone Ext.	Phone (Other) Ext.

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

Civil status
☐ Single
☐ Married or civil union[2] ☐ Common-law spouse[2] ☐ Widowed[2] ☐ Divorced[2] ☐ Separated[2]

Note 2: Since (Year / Month / Day)

3. INFORMATION CONCERNING A PREVIOUS GROUP INSURANCE CONTRACT

☐ I am or was insured with La Capitale. Last contract number: _____

☐ I was insured under another group insurance contract. (Please include a copy of recent documents confirming the insurance coverage you had and the life insurance amounts.) Termination date: (Year / Month / Day)

4. COVERAGE

HEALTH INSURANCE	I want to apply	I want to change	I want to remove
Individual coverage	☐	☐	☐
Family coverage	☐	☐	

Reason of modification: _____

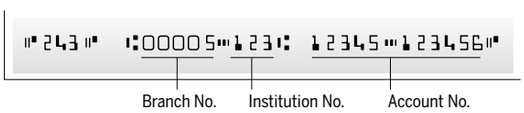
Date of the event: (Year / Month / Day)

BASIC LIFE INSURANCE	I want to apply	I want to remove
OF PARTICIPANT (Mandatory for participation in the other Life Insurance benefits)		
Under age 65: 1 x annual salary	☐	☐
Age 65 or over: $5,000	☐	☐
OF DEPENDENT	☐	☐

PARTICIPANT'S OPTIONAL LIFE INSURANCE	I want to apply	I want to remove
If under age 70: 1 to 10 units of $5,000 _____	☐	☐
If age 70 and over: 1 to 8 units of $5,000 _____	☐	☐

☐ **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. _____

5. INFORMATION ABOUT DEPENDENTS

	Full name	Gender M F	Date of birth (YY/MM/DD)	Dependent child with a functional impairment[3]	Fill this out for a dependent child over age 17 or 20 who is a full-time student.[4] Start date of the school year (YY/MM/DD)	End date of the school year (YY/MM/DD)
Spouse		☐ ☐				
Children		☐ ☐		☐		
		☐ ☐		☐		
		☐ ☐		☐		

Note 3: Please contact customer service for how to proceed.
Note 4: Please check eligible age under your contract. La Capitale reserves the right to ask you for written proof from the institution attended at any time.

6. WITHDRAWAL OF DEPENDENTS

Please fill in section 4 if you wish to change your group insurance benefits and indicate the reason for modification.

Full name	Full name

7. BENEFICIARY DESIGNATION (for Life Insurance coverage)

Revocable	Irrevocable	Full name	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 rights 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.

8. DESIGNATION OF A TRUSTEE FOR 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**

9. METHOD OF INSURANCE PREMIUM PAYMENT

☐ **Preauthorized Debit Agreement (PAD) – Personal** (Please attach a cheque specimen)

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 is 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. 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.

X _____ Date: ____ ____ ____ (Year Month Day)
Signature of account holder

X _____ Date: ____ ____ ____ (Year Month Day)
Signature of second account holder, if required

☐ ***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: ____ ____ ____ (Year Month Day) ____ ____ ____ ____ ____
Signature of policyholder — Social Insurance No. (SIN) (Mandatory for enrolling in this method of payment)

☐ **I would like monthly billing** (payment by cheque)

X _____ Date: ____ ____ ____ (Year Month Day)
Signature of policyholder

10. PARTICIPANT'S AUTHORIZATION

"I 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 myself, as the case may be, 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 as valid as the original.

X _____ Date: ____ ____ ____ (Year Month Day)
Signature of participant

11. NOTICE

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

You may access your file or request a correction for inaccurate or incomplete information by submitting a request in writing to the Information Access Officer in the *Administration Department*.

To serve its customers, La Capitale Financial Group Inc., its subsidiaries and authorized representatives may use your personal information (name, address, telephone 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 type of information, please write to us at the address below.

For Customer Service:
Tel: 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

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

C1011-0A (05-2018)