

## APPLICATION FOR DIRECT DEPOSIT OF BENEFITS

625 Jacques-Parizeau St, P.O. Box 1500, Quebec QC G1K 8X9 418 644-4200 or 1 800 463-4856 • Fax: 418 646-0888 prest.sante@lacapitale.com

GROUP NO.	EMPLOYER NO.	IDENTIFICATION NO.

- PARTICIPANT'S IDENTIFICATION			•		
AMILY NAME	FI	RST NAME			
NO. STREET		APT.	PHONE AT HOME	(	)
CITY		POSTAL CODE	PHONE AT WORK	(	)
2 - AUTHORIZATION					
I hereby authorize La Capitale Civil Service Insurer information; no cheque specimen is requi	Inc., to deposit my be ired.	nefits in my bank ac	count. <b>Please comp</b>	lete the f	following bank
Branch No. In:	stitution No.	Accou	nt No.		
Coverage:	Dental	Health	☐ Disability		
Please fill out and return this form to:	La Capitale Civil S 625 Jacques-Pariz P.O. Box 1500 Quebec QC G1K				
3 -SIGNATURE OF THE PARTICIPANT Signed in	, on the	_ day of			20
Signature of the participant					