AUTHORIZATION / REVOCATION FOR THE DISCLOSURE OF PERSONAL INFORMATION

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.

1 – INFORMATION ABOUT THE PARTICIPANT

LAST NAME		FIRST NAME	
ADDRESS No. STREET		APT.	HOME TELEPHONE
TOWN/CITY	POSTAL CODE		DATE OF BIRTH

Once it has been duly completed and signed, this form may be returned to La Capitale Civil Service Insurer Inc. (La Capitale) by email, fax or regular mail. La Capitale's contact information is provided at the top of this form.

2 - AUTHORIZATION

I, the undersigned, authorize La Capitale to disclose to:

_____
(Please print the name of the person(s) authorized to receive the personal information concerning you)

Date of birth: _____ Relationship to the participant: _____
year – month - day

Notes:
- This authorization is valid as of the date it is signed, at all times and under all circumstances, until I revoke it in writing.
- Please note that the person authorized through this form for the transmission of personal information will have access to your group insurance file for matters with respect to disability, the reimbursement of medical expenses and fees of healthcare professionals, your benefits, premiums charged and certain information with regard to your Life insurance.

3. REVOCATION

I, the undersigned, revoke the rights of the following person or persons to access the information contained in my file at La Capitale Civil Service Insurer Inc.:

_____
Please print name(s)

4 – SIGNATURE OF PARTICIPANT

Signed at _____, on this _____ day of _____ 20 ____.

_____ _____
Signature of participant Signature of witness

Employers may reproduce this form as their individual needs require.