AUTHORIZATION FOR THE DISCLOSURE OF MEDICAL INFORMATION

La Capitale Civil Service Insurer Inc.
625 Jacques-Parizeau St, P.O. Box 1500, Quebec QC G1K 8X9
418 644-4200 ou 1 800 463-4856 • Fax: 418 646-1313 • adm.collectif@lacapitale.com

GROUP NO.	EMPLOYER NO.	IDENTIFICATION NO.

1 – PARTICIPANT'S IDENTIFICATION

FAMILY NAME | FIRST NAME

ADDRESS (NO. STREET APT.) | PHONE AT HOME ( )

CITY | POSTAL CODE | PHONE AT WORK ( )

2 - AUTHORIZATION

TO THE MEDICAL DIRECTOR

I authorize La Capitale Civil Service Insurer Inc. to contact the doctor mentioned hereafter in order to explain the decision for my group insurance request.

Doctor's name _____

Address _____

_____

_____

Postal code _____

Insurance request for:

Name _____

Address _____

_____

_____

Postal code _____

Date of birth _____

3 –SIGNATURE OF THE PARTICIPANT

Signed in _____, on the _____ day of _____ 20 ____.

_____ Signature of the participant

_____ Signature of the witness

Each employer may reprint this form for its needs.