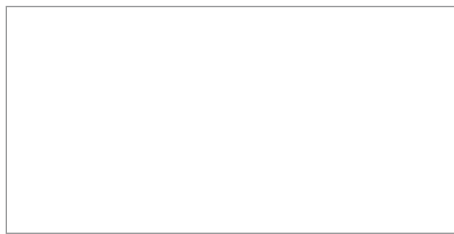


RETURN THIS FORM TO:  
APRFAE  
8550 Pie-IX Blvd, Suite 100  
Montreal QC H1Z 4G2



GROUP INSURANCE APPLICATION  
 MODIFICATIONS TO GROUP INSURANCE

Group No.  
0 | 0 | 9 | 9 | 9 | 5

APRFAE Member No. – Reserved for the use of APRFAE

Identification No. at La Capitale

## 1. INFORMATION ABOUT RETIREE PARTICIPANT

Name of the group FÉDÉRATION AUTONOME DE L'ENSEIGNEMENT		Employer's name before retirement	
Last name		First name	
		Date of birth Year Month Day	
Gender <input type="checkbox"/> M <input type="checkbox"/> F	Language: <input type="checkbox"/> English <input type="checkbox"/> French	No., street, apt.	
		City	
Province	Postal code	Main phone Ext.	Phone (Other) Ext.
Email address <sup>1</sup>		<b>Note 1:</b> By giving my email address, I consent to receiving only documents that concern my insurance policy.	
		Retirement date Year Month Day	
Civil status <input type="checkbox"/> Single <input type="checkbox"/> Married or civil union <sup>2</sup> <input type="checkbox"/> Common-law spouse <sup>2</sup> <input type="checkbox"/> Widowed <sup>2</sup> <input type="checkbox"/> Divorced <sup>2</sup> <input type="checkbox"/> Separated <sup>2</sup>		<b>Note 2:</b> Since Year Month Day	

## 2. COVERAGES

				I want to apply	I want to remove
<b>LIFE AND ACCIDENTAL DEATH INSURANCE<sup>3</sup></b>			<b>Age at the time of death</b>		
<b>Choice of amount<sup>4</sup></b>			<b>Under age 60</b>	<b>Age 60 to 64</b>	<b>Age 65 or over</b>
– Option 1 <sup>5</sup>			\$20,000	\$15,000	\$10,000
– Option 2 <sup>6</sup>			\$40,000	\$30,000	\$20,000
– Option 3 <sup>6</sup>			\$60,000	\$45,000	\$30,000
<b>LIFE INSURANCE FOR RETIREE'S DEPENDENTS<sup>7</sup></b>				<input type="checkbox"/>	<input type="checkbox"/>

**Note 3:** A benefit equal to the amount of life insurance provided in the event of accidental death.

**Note 4:** Once your choice is made, you may only reduce amounts of insurance. You may not increase amounts under any circumstances.

**Note 5:** Option 1 may be selected by a participant who was not covered under the life insurance plan as an employee.

**Note 6:** Options 2 and 3 may be selected only if, before retirement, the participant held an equal or greater amount of insurance under the life insurance plan for employees.

**Note 7:** Only available if held before retirement.

## 3. INFORMATION ABOUT DEPENDENTS

	Full name	Gender M F	Date of birth (YY/MM/DD)	Dependent child with a functional impairment <sup>8</sup>	Fill this out for a dependent child over age 17 or 20 who is a full-time student. <sup>9</sup>	
					Start date of the school year (YY/MM/DD)	End date of the school year (YY/MM/DD)
Spouse		<input type="checkbox"/> <input type="checkbox"/>				
Children		<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/>		
		<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/>		
		<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/>		
		<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/>		

**Note 8:** Please contact customer service for how to proceed.

**Note 9:** 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.

## 4. WITHDRAWAL OF DEPENDENTS

Please fill in section 2 if you wish to change your group insurance benefits.

Full name	Full name	Effective date Year Month Day
-----------	-----------	----------------------------------

## 5. BENEFICIARY DESIGNATION (for Life Insurance coverage)

Revocable	Irrevocable	Full name	Relationship to participant
<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	<input type="checkbox"/>		

**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.

## 6. 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

## 7. METHOD OF 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](http://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](http://www.payments.ca).

X

Signature of account holder

Date: 

Year	Month	Day	

X

Signature of second account holder, if required

Date: 

Year	Month	Day	

- 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

Signature of contributor

Date: 

Year	Month	Day	

 Social Insurance No. (SIN) (Mandatory for enrolling in this method of payment)

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

X

Signature of account holder

Date: 

Year	Month	Day	

## 8. PARTICIPANT'S AUTHORIZATION

I **authorize** La Capitale Civil Service Insurer Inc. to use the information contained in this application, including my Social Insurance Number, for administrative purposes.

I **certify** that the information provided on this application is accurate and complete. Furthermore, I acknowledge that I have read the notice concerning the files and personal information below and kept a copy of this form for my records.

X

Participant's signature

Date: 

Year	Month	Day	

## 9. SIGNATURE OF APRFAE'S REPRESENTATIVE

X

Date: 

Year	Month	Day	

## 10. NOTICE

La Capitale wishes to advise you that information collected during this transaction will be kept in a file under the subject of "Group Insurance". Access to this file is restricted to employees and service providers, on a need-to-know basis, as required to fulfil their duties. Notwithstanding exceptions provided for by law, no other person may access your file without your authorization. Your file will be kept at the address below.

You may access your file by submitting a request in writing to the information Access Officer in the Administration Department. If any of your personal information is inaccurate, incorrect or incomplete, you may submit a request in writing to have it corrected.

<b>To contact our Customer Service</b>	Telephone: 418 644-4200	La Capitale Civil Service Insurer Inc.
	Toll free: 1 800 463-4856	625 Jacques-Parizeau St, PO Box 1500
	Email: <a href="mailto:adm.collectif@lacapitale.com">adm.collectif@lacapitale.com</a>	Quebec QC G1K 8X9   <a href="http://lacapitale.com">lacapitale.com</a>

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