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 INSURANCE APPLICATION
☐ MODIFICATION(S) TO GROUP INSURANCE
☐ **SUBMITTED BY THE PORTAL**

GROUP NO.	EMPLOYER NO.	IDENTIFICATION NO.
001008		

1 - INFORMATION ABOUT PARTICIPANT

GROUP'S NAME	EMPLOYER'S NAME	EMPLOYEE'S NO.
FNEEQ (CEGEPs)		

FIRST NAME	LAST NAME	GENDER	DATE OF BIRTH (Y M D)
		☐ M ☐ F	

ADDRESS (NO. STREET APT.)	CORRESPONDENCE	WORK SCHEDULE
	☐ E ☐ F	☐ FULL TIME ☐ PART TIME: _____ (%)

TOWN/CITY	POSTAL CODE

MARITAL STATUS: ☐ SINGLE ☐ MARRIED OR JOINED BY A CIVIL UNION* ☐ WIDOWED* ☐ COMMON-LAW SPOUSE* ☐ DIVORCED* ☐ SEPARATED* * SINCE _____ (Y M D)

CURRENT TITLE	EMPLOYMENT DATE (Y M D)	ELIGIBILITY DATE (Y M D)	EMPLOYMENT STATUS	ANNUAL SALARY ACCORDING TO THE % OF TASK
			☐ PERMANENT ☐ CONTRACTUAL _____	

Were you insured under the contract of the FNEEQ before today? ☐ Yes ☐ No (Y M D)

If so, indicate employer's name: _____ and termination date: _____

2- BENEFITS

	I WANT TO APPLY			I WANT TO CHANGE MY COVERAGE					
				ADD			REMOVE		
MANDATORY BENEFITS	**BASIC (Module A)**	**STANDARD (Module B)**	**EXTENDED (Module C)**	**BASIC (Module A)**	**STANDARD (Module B)**	**EXTENDED (Module C)**	**BASIC (Module A)**	**STANDARD (Module B)**	**EXTENDED (Module C)**
– HEALTH INSURANCE The coverage status selected will also apply to Dental Care Insurance, if applicable. Coverage status – Individual – Single-Parent (no spouse) ☐ Exemption[1] – Couple (no eligible children) – Family	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐
	Reduction of coverage is allowed only after expiry of a 36-month participation period for the coverage level selected.								
– LONG-TERM DISABILITY INSURANCE[2]	☐			☐			☐		
OPTIONAL BENEFITS	**BASIC (Option 1)**	**EXTENDED (Option 2)**		**BASIC (Option 1)**	**EXTENDED (Option 2)**		**BASIC (Option 1)**	**EXTENDED (Option 2)**	
– DENTAL CARE INSURANCE The coverage status must be the same for Health Insurance and Dental Insurance when these two benefits are selected, unless the participant chooses Health Insurance exemption. Coverage status – Individual – Single-Parent (no spouse) ☐ Exemption[1, 3] – Couple (no eligible children) – Family	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐		☐ ☐ ☐ ☐	☐ ☐ ☐ ☐		☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	
Extended coverage (Option 2) is available only if Extended coverage (Module C) has been selected for Health insurance.	**Reduction or termination of coverage is allowed only after expiry of a 36-month participation period for the coverage level selected.**								
– PARTICIPANT'S BASIC LIFE INSURANCE AND CRITICAL ILLNESS INSURANCE (mandatory to apply for other Life Insurance benefits)	☐ 1 X annual salary (min. $35,000) ☐ 2 X annual salary (min. $70,000)			☐ 1 X annual salary (min. $35,000) ☐ 2 X annual salary (min. $70,000)			☐ 1 X annual salary (min. $35,000) ☐ 2 X annual salary (min. $70,000)		
– DEPENDENTS' LIFE INSURANCE	☐			☐			☐		
– PARTICIPANT'S OPTIONAL LIFE INSURANCE[4] Participant must have Basic Life Insurance coverage equal to 2 X the annual salary.	**1 to 10 units of $25,000** _____ X $25,000			**1 to 10 units of $25,000** _____ X $25,000			**1 to 10 units of $25,000** _____ X $25,000		
– SPOUSE'S OPTIONAL LIFE INSURANCE[4] This coverage is available only if Dependents' Life Insurance has been selected.	**1 to 10 units of $25,000** _____ X $25,000			**1 to 10 units of $25,000** _____ X $25,000			**1 to 10 units of $25,000** _____ X $25,000		

1. To be exempted from coverage under the Health or Dental Care Insurance plan, participants must provide the employer with proof of insurance under an equivalent group insurance plan.
2. This benefit is mandatory for all permanent employees and initially optional for all other classes of employees.
3. Basic coverage (Option 1) is available even if the participant is exempted in Health Insurance.
4. This benefit is always subject to the Insurer's approval of evidence of insurability. Please complete the Declaration of Insurability form (P015).

3 - REASON(S) FOR CHANGING MY COVERAGE

EFFECTIVE DATE OF THE EVENT
Y M D

LEAVE WITHOUT PAY, PARENTAL OR MATERNITY LEAVE, TEMPORARY LAYOFF, BIRTH, MARRIAGE, ETC.

PLANNED DATE OF RETURN TO WORK (IF APPLICABLE)
Y M D

PLEASE:

A) ☐ MODIFY MY GROUP INSURANCE BENEFITS – (PART 2)
B) ☐ MAINTAIN ALL MY GROUP INSURANCE BENEFITS
C) ☐ CANCEL ALL MY GROUP INSURANCE BENEFITS EXCEPT THOSE INCLUDING PRESCRIPTION DRUGS AND DENTAL CARE INSURANCE PLANS

4 - INFORMATION ABOUT DEPENDENTS

Spouse's first name	Spouse's last name	Gender M F	Date of birth Y M D	Children's first names	Children's last names	Gender M F	Date of birth Y M D	Student	Functional impairment**
		☐ ☐				☐ ☐		☐	☐
						☐ ☐		☐	☐
						☐ ☐		☐	☐
						☐ ☐		☐	☐
						☐ ☐		☐	☐

** Please complete the "Dependent child status for a person with a total disability or functional impairment" form and attach it to this form.

5 - DESIGNATION OF BENEFICIARY

(FOR LIFE INSURANCE BENEFITS)

☐ REVOCABLE ☐ IRREVOCABLE

ATTENTION: 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. **PROVINCE OF ONTARIO:** Designating a legally married spouse as a beneficiary 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.

FULL NAME: _____ RELATIONSHIP TO PARTICIPANT: _____

6 - DESIGNATION OF A TRUSTEE (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: _____

ADDRESS NO. STREET APT. CITY PROVINCE POSTAL CODE

7 - PARTICIPANT'S DECLARATION

I hereby agree to the provisions of the policy and consent to the required premiums being deducted from my salary, as applicable. I agree to my social insurance number being used for administrative purposes by La Capitale Civil Service Insurer Inc. (La Capitale).

I authorize my employer, the Policyholder, La Capitale or its reinsurers as well as its representatives, agents and service providers to provide, receive and exchange between themselves any personal information regarding my eligibility, insurability and claims for benefits under the plan and those of my dependents, if applicable. In the event of death, I specifically authorize the Policyholder, the employer, the beneficiary, the heir or the liquidator of my estate to provide to La Capitale, or its service providers, any information for the processing of my file.

This authorization is valid for the purposes of this contract and for any amendments, extensions or renewals thereof. A photocopy of this authorization is considered as valid as the original if used for the exchange of information.

Participant's signature or, if a minor, signature of legal guardian	Telephone (day)	Telephone (other)	Date Y M D

8 - SIGNATURE OF EMPLOYER'S REPRESENTATIVE

	Telephone	Date Y M D

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.

When you take out a contract with La Capitale, your name and address are included in our client database to help us provide you with quality service and information on new products designed to meet your needs. If you would prefer to have your contact details removed from our distribution list, please call or write to let us know.

To contact the customer service:
Telephone: 418 644-4200 or Toll free: 1 800 463-4856
adm.collectif@lacapitale.com • lacapitale.com

La Capitale Civil Service Insurer Inc.
625 Jacques-Parizeau St, P.O. Box 1500
Quebec QC G1K 8X9

Please keep a copy of this form for your records and send the original to La Capitale.