La Capitale

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

☐ **GROUP INSURANCE APPLICATION**
☐ **MODIFICATIONS TO GROUP INSURANCE**

1. INFORMATION REGARDING INSURANCE FILE

Group No.	APRFAE Member No. – **Reserved for the use of APRFAE**	Identification No. at La Capitale
1 0 9 9 9 5		

Name of the group: **ASSOCIATION DE PERSONNES RETRAITÉES DE LA FÉDÉRATION AUTONOME DE L'ENSEIGNEMENT**

Information regarding time of retirement

Employer's No.	Employer's name	Retirement date (Year / Month / Day)	Annual salary before retirement

2. INFORMATION ABOUT PARTICIPANT

Last name	First name	Date of birth (Year / Month / Day)

Gender	Language	No., street, apt.	City
☐ M ☐ F	☐ English ☐ French		

Province	Postal code	Main phone	Ext.	Phone (Other)	Ext.

Email address[1]

Note 1: By giving my email address, I consent to receiving only documents that concern my insurance policy.

Civil status
☐ Single
☐ Married or civil union[2] ☐ Common-law spouse[2] ☐ Widowed[2] ☐ Divorced[2] ☐ Separated[2]

Note 2: Since (Year / Month / Day)

3. INFORMATION ABOUT THE PREVIOUS CONTRACT

☐ I am or I was insured under a group health insurance plan.

Contract No.: _____ Insurer: _____

Identification No., if insured by La Capitale: _____ Contract termination date: (Year / Month / Day)

If your insurer was not La Capitale Civil Service Insurer Inc. (La Capitale), attach a document that demonstrates you were covered by a group health insurance plan and also includes the contract termination date and the name of each insured. If you submit your application more than 90 days after the contract termination date, please complete the Declaration of Insurability form and attach it to this form.

☐ I am **currently** insured under an individual health insurance conversion product, including travel insurance for a minimum period of 30 days, obtained when the group insurance plan terminated. Attach proof of coverage that was in force within the last 90 days.

Product name: _____ Insurer: _____

Insurance will take effect 30 days after this form is signed or, if evidence of insurability is required, on the date such evidence is approved.

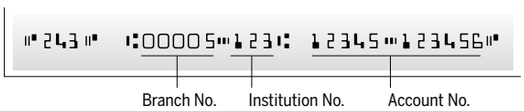
4. PLAN

			I want to apply	I want to remove
HEALTH INSURANCE[3] Minimum participation period Basic Option: **24 months** Intermediate Option and Enhanced Option: **36 months**	**Single module selection**	**Single coverage status selection**		
	☐ Basic Option	– Individual	☐	☐
	☐ Intermediate Option	– Single-parent[4]	☐	☐
	☐ Enhanced Option	– Family[4]	☐	☐

Note 3: The policyholder must maintain the selected plan for the minimum period of participation indicated below. This period begins on the effective date of the plan, and it will not be possible to make changes until January 1 following the minimum participation period. However, certain life events may allow a policyholder to review his or her plan regardless of the minimum period.
Note 4: If dependents are or were insured under a contract other than the one indicated in Section 2, attach proof of coverage held if it ended within the last 30 days. If dependents were not insured under any contracts indicated in Section 2 or if they were insured under an insurance contract that terminated more than 30 days ago, they must complete the Declaration of Insurability form and attach it to this form.

☐ **DIRECT DEPOSIT SERVICE FOR REIMBURSEMENT OF HEALTHCARE EXPENSES**

I authorize La Capitale to deposit my health insurance and/or dental care insurance benefits in my bank account. (Please complete the following bank information; no cheque specimen is required).



Branch No. Institution No. Account No.

5. REASON FOR MODIFICATION

_____
Birth or adoption of a child, separation or divorce, death of the spouse or a dependent, termination of eligibility of the last dependent child, termination of the minimum participation period, etc.

Effective date of the event: (Year / Month / Day)

6. INFORMATION ABOUT DEPENDENTS

	Full name	Gender M F	Date of birth (YY/MM/DD)	Dependent child with a functional impairment[5]	Fill this out for a dependent child over age 18 who is a full-time student.[6]	
					Start date of the school year (YY/MM/DD)	End date of the school year (YY/MM/DD)
Spouse		☐ ☐				
Children		☐ ☐		☐		
		☐ ☐		☐		
		☐ ☐		☐		
		☐ ☐		☐		

Note 5: Please contact customer service for how to proceed.
Note 6: La Capitale reserves the right to ask you for written proof from the institution attended at any time.

7. WITHDRAWAL OF DEPENDENTS

Please fill in section 4 if you wish to change your group insurance benefits and indicate the reason for modification in section 5.

Full name	Full name	Effective date
		Year Month Day

8. METHOD OF PREMIUM PAYMENT

☐ **Preauthorized Debit Agreement (PAD) – Personal** (Please attach a cheque specimen if the method of payment is retained)

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.
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.

X _____ Date: Year Month Day
Signature of account holder

X _____ Date: Year Month Day
Signature of second account holder, if required

☐ ***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 _____ Date: Year Month Day _____
Signature of contributor — Social Insurance No. (SIN) (Mandatory for enrolling in this method of payment)

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

X _____ Date: Year Month Day
Signature of account holder

9. 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 _____ Date: Year Month Day
Participant's signature

10. SIGNATURE OF APRFAE'S REPRESENTATIVE

X _____ Date: Year Month Day

11. 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.

To contact our Customer Service
Telephone: 418 644-4200
Toll free: 1 800 463-4856
Email: adm.collectif@lacapitale.com
La Capitale Civil Service Insurer Inc.
625 Jacques-Parizeau St, PO Box 1500
Quebec QC G1K 8X9 | lacapitale.com

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

C109995-1A (02-2019)