Regroupement loisir et sport du Québec / Centre québécois de services aux associations
dlavoie@loisirsport.qc.ca
514 252-3128
1 800 932-3735, ext.1
4545 Pierre-De-Coubertin Avenue
Montreal QC H1V 0B2

La Capitale Insurance and Financial Services

☐ GROUP INSURANCE APPLICATION
☐ MODIFICATION(S) TO GROUP INSURANCE

COMPLETE PLAN

GROUP NO.	EMPLOYER NO.	IDENTIFICATION NO.
001962		

1- INFORMATION ABOUT PARTICIPANT

GROUP NAME: REGROUPEMENT LOISIR ET SPORT DU QUÉBEC / CENTRE QUÉBÉCOIS DE SERVICES AUX ASSOCIATIONS
EMPLOYER NAME:
EMPLOYEE No.:
LAST NAME:
FIRST NAME:
GENDER: ☐ M ☐ F
DATE OF BIRTH: Y M D
ADDRESS: NO. STREET APT.
CORRESPONDENCE: ☐ E ☐ F
TELEPHONE NO. HOME ( )
CITY:
POSTAL CODE:
TELEPHONE NO. WORK ( )
MARITAL STATUS: ☐ SINGLE ☐ MARRIED* ☐ WIDOWED* ☐ COMMON-LAW SPOUSE* ☐ DIVORCED* ☐ SEPARATED* ☐ CIVIL UNION*
* SINCE _____ Y M D
WORK ARRANGEMENT: ☐ FULL TIME ☐ PART TIME: _____ _____(%) OR _____ (HRS/WEEK)
JOB TITLE:
ANNUAL SALARY:
EMPLOYMENT DATE: Y M D
ELIGIBILITY DATE: Y M D
EMPLOYMENT STATUS: ☐ PERMANENT ☐ OTHER (SPECIFY): _____

2- BENEFITS

CHOICE OF OPTIONS (HEALTH AND DENTAL CARE INSURANCE)

- OPTION A (MINIMUM PARTICIPATION PERIOD OF 24 MONTHS) ☐
- OPTION B (MINIMUM PARTICIPATION PERIOD OF 24 MONTHS) ☐
- OPTION C (MINIMUM PARTICIPATION PERIOD OF 48 MONTHS) ☐

CHOICE OF COVERAGE

- **HEALTH AND DENTAL CARE INSURANCE**
  - INDIVIDUAL ☐
  - FAMILY ☐
  - SINGLE-PARENT (NO SPOUSE WITH CHILD(REN)) ☐
  - EXEMPTED* ☐
- **BASIC LIFE AND ACCIDENTAL DEATH OR DISMEMBERMENT INSURANCE (Coverage based on the option chosen for health insurance)** ☐
- **OPTIONAL LIFE INSURANCE (Please specify your smoking patterns)**
  - ☐ **PARTICIPANT (1 to 25 units of $10,000)** ☐ SMOKER ☐ NON-SMOKER AMOUNT: _____ X $10,000
  - ☐ **SPOUSE (1 to 25 units of $10,000)** ☐ SMOKER ☐ NON-SMOKER AMOUNT: _____ X $10,000
- **SHORT-TERM DISABILITY INSURANCE (MANDATORY UNDER THE PROVISIONS OF THE CONTRACT)** ☐
- **LONG-TERM DISABILITY INSURANCE (MANDATORY UNDER THE PROVISIONS OF THE CONTRACT)** ☐

* **IMPORTANT: TO BE EXEMPTED FROM COVERAGE UNDER THE HEALTH AND/OR DENTAL CARE INSURANCE BENEFITS, THE PARTICIPANT MUST PROVIDE THE EMPLOYER WITH PROOF OF COVERAGE UNDER ANOTHER GROUP INSURANCE PLAN WITH SIMILAR BENEFITS.**

3- MODIFICATION(S)

REASON(S) _____
LEAVE WITHOUT PAY, PARENTAL OR MATERNITY LEAVE, TEMPORARY LAYOFF, BIRTH, MARRIAGE, DISABILITY, ETC.

PLEASE:

A) ☐ MODIFY MY GROUP INSURANCE BENEFITS - **CHECK (✓) ALL DESIRED BENEFITS AGAIN** (PART 2)
B) ☐ MAINTAIN ALL MY GROUP INSURANCE BENEFITS
C) ☐ CANCEL ALL MY GROUP INSURANCE BENEFITS EXCEPT FOR MY PRESCRIPTION DRUG INSURANCE PLAN

EFFECTIVE DATE OF THE EVENT: Y M D

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

4- IDENTIFY YOUR DEPENDENTS (IF FAMILY, SINGLE-PARENT OR EXEMPTED INSURANCE COVERAGE)

	First name	Last name	Gender	Date of birth (Y M D)
Spouse:			☐ M ☐ F	
Child(ren) :			☐ M ☐ F	
			☐ M ☐ F	
Child(ren) :			☐ M ☐ F	
			☐ M ☐ F	
			☐ M ☐ F	

5- BENEFICIARY'S FULL NAME (FOR LIFE INSURANCE COVERAGE)

CAUTION: DESIGNATING AN IRREVOCABLE BENEFICIARY CAN HAVE SIGNIFICANT CONSEQUENCES. TO REPLACE A BENEFICIARY DESIGNATED AS IRREVOCABLE, YOU MUST OBTAIN THE BENEFICIARY'S CONSENT AND, IF A MINOR, THE CONSENT OF THE BENEFICIARY'S LEGAL REPRESENTATIVE.

DESIGNATION: _____

RELATIONSHIP TO THE PARTICIPANT: _____

CHECK YOUR CHOICE
☐ REVOCABLE
☐ IRREVOCABLE

6- AUTORIZATION

"I hereby authorize my employer to deduct the required premiums from my salary, La Capitale Insurance and Financial Services Inc. and the plan administrator to use my social insurance number for administration purposes. Furthermore, I authorize any physician, any other professional and any intervening party in the field of health and rehabilitation, as well as any public or private health and social services institution, any insurance company, as well as any reinsurer, any public or private organization, any information agency that may receive such a mandate, any market intermediary, any employer or ex-employer, the policyholder as well as any person holding files or information, particularly medical records pertaining to myself, as the case may be, to provide to La Capitale Insurance and Financial Services Inc. or mandataries, any information it may hold that may be required for the processing of my file.

I also authorize La Capitale Insurance and Financial Services Inc. to transmit such information to the aforementioned persons when necessary, within the scope of its activities and the processing of my file.

In the event of death, I specifically authorize the policyholder, the employer, the beneficiary, my heirs or the liquidator of my estate to provide La Capitale Insurance and Financial Services Inc. or mandataries when necessary, with all information or authorizations required for the processing of my file."

This authorization shall be valid for the purposes of this contract and for any amendments, extensions or renewals thereof. A photocopy of this authorization shall be considered as valid as the original.

_____ ( ) _____ _____
Participant's signature or if a minor, the legal representative — Telephone — Date

(PLEASE READ THE NOTICE ON THE REVERSE)

7- PARTICIPANT'S EMAIL ADDRESS

_____

Please preserve a copy (employee and employer) and transmit the original to La Capitale.

N O T I C E

La Capitale Insurance and Financial Services Inc. (hereafter 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 agents of the company, on a need-to-know basis, as required to fulfil their duties or carry out their assignments. 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.

La Capitale Insurance and Financial Services Inc.
625 Saint-Amable St.
P.O. Box 1500
Quebec QC G1K 8X9

Customer Service
Telephone: 418 644-4200
or
Toll free: 1 800 463-4856