APPLICATION
HEALTHCARE INSURANCE
PERSPECTIVE

La Capitale Insurance and Financial Services Inc.
625 Jacques-Parizeau St, PO Box 16040, Stn Terminus, Quebec QC G1K 9Z9
418 528-9995 or 1 866 612-3473 • Fax: 418 643-8597 or 1 866 375-9780
directsales@lacapitale.com

POLICY NO. 003992

RESERVED FOR LA CAPITALE

	IDENTIFICATION NO.

1- INFORMATION ABOUT PARTICIPANT

LAST NAME		FIRST NAME	
DATE OF BIRTH Y M D	GENDER ☐ M ☐ F	LANGUAGE OF CORRESPONDENCE ☐ E ☐ F	TELEPHONE
ADDRESS NO. STREET			APT.
CITY		PROVINCE	POSTAL CODE
EMAIL ADDRESS†		† By giving my email address, I consent to receiving only documents that pertain to my insurance policy and the VIVA workplace health and wellness program, which is included in the policy.	

MARITAL STATUS
☐ SINGLE ☐ MARRIED* ☐ WIDOWED* ☐ COMMON-LAW SPOUSE* ☐ DIVORCED* ☐ SEPARATED* ☐ IN A CIVIL UNION* *SINCE: ________ Y M D

2- INFORMATION CONCERNING A PREVIOUS GROUP INSURANCE CONTRACT

☐ I am or was insured with La Capitale. Number of last contract with La Capitale: ____________

Date of termination of employment or of your group insurance: ________ Y M D

☐ I am not or have never been insured with La Capitale (If applicable, please attach a document that confirms that you held group health insurance coverage, which terminated less than 60 days ago.)

3- CHOICE OF COVERAGE, PLAN AND OPTIONAL COVERAGE SUPPLEMENT (✓)

Important note: The participant will have to maintain the minimum participation period indicated below for the plan choosen. This period will begin on the effective date of the plan and it will not be possible to make changes until January 1 following the participation period. However, certain life events may allow a participant to review his or her plan regardless of the minimum period.

COVERAGE		PLANS	ENROLMENT	CHANGE
☐ **Individual**	**You must choose only one of these plans**	**Basic** (minimum participation period: **24 months**)	☐	☐
☐ **Family**		**Intermediate** (minimum participation period: **36 months**)	☐	☐
☐ **Single-Parent**		**Enriched** (minimum participation period: **36 months**)	☐	☐

OPTIONAL COVERAGE SUPPLEMENT

At the time of your plan selection, you can enrol in the **optional coverage supplement**. The coverages under the optional coverage supplement, which cannot be purchased separately, are added to your current plan (Basic, Intermediate or Enriched), under the same coverage status (Individual, Family or Single-Parent).

☐ I would like to enrol in the **optional coverage supplement** (minimum participation period: 24 months)

TYPES OF COVERAGE

- **Coordination of prescription drug expense reimbursement with the public plan (deductible and coinsurance), according to the coinsurance percentage specified in your current plan for prescription drug coverage** (Base, Intermediate, Enriched)
- **Vision Care**
  Expenses reimbursed at 100% – Maximum reimbursement of $150/24 months for eyeglass frames and lenses, and contact lenses, and $50/24 months for an eye exam
- **Dental Care**
  Expenses reimbursed at 80% - Maximum reimbursement of $500/calendar year for all of the following services:
  - Preventive services: One examination per period of 9 consecutive months
  - Basic restorative services
  - Major restorative services

4- IDENTIFY YOUR DEPENDENTS

	First name	Last name	Gender M	Gender F	Date of birth Y M D	Student
Spouse:			☐	☐		
Children:			☐	☐		☐
			☐	☐		☐

	First name	Last name	Sexe M	Sexe F	Date of birth Y M D	Student
Children:			☐	☐		☐
			☐	☐		☐
			☐	☐		☐

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5- METHOD OF PREMIUM PAYMENT

A. ☐ **RETRAITE QUÉBEC**
As a Retraite Québec benefit recipient, I authorize this organization to deduct the required contributions monthly from my pension cheque until I give notice otherwise.
I am indicating my Social Insurance Number, as it is required by this organization.

Social Insurance Number (SIN):_______________________

Participant's signature: _______________________ Date:_______________________

B. ☐ **ANNUAL INVOICE**
Participant's signature: _______________________ Date: _______________________

C. ☐ **PREAUTHORIZED DEBIT (PAD) – TYPE OF PAD: Personal**
I, the undersigned, authorize La Capitale Insurance and Financial Services Inc. (La Capitale) to debit the bank account printed on the enclosed cheque specimen or the bank account identified below, for the fixed monthly amounts required for the payment of premiums payable to La Capitale. Payment will be debited on the 15th of each month.

Bank account information: Please enclose a cheque specimen **or** provide the following bank information:

Branch No.	Institution No.	Account No.	Check digit	Social Insurance Number (SIN)

You will receive notice at least ten (10) days prior to the first PAD confirming the amount and date of PADs. This agreement may be cancelled upon receipt by La Capitale of thirty (30) days' written notice prior to the scheduled date of the next PAD. Furthermore, you are entitled to certain recourses if a debit does not comply with the terms and conditions of this agreement. For example, you are entitled to receive reimbursement for any unauthorized PAD or any PAD not complying with the terms and conditions of this agreement. For a copy of a cancellation form or for further information on this agreement or your recourses, please contact La Capitale or go to www.cdnpay.ca.

_______________________ Date: _______________________
Signature(s) according to requirements for withdrawals from this account

6- AUTHORIZATION AND DECLARATION

"I hereby authorize La Capitale Insurance and Financial Services Inc. (La Capitale) 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, as well as any person holding personal files or information, particularly medical records pertaining to myself, as the case may be, to provide to La Capitale or its agents, any information that may be required for the processing of my file.
I also authorize La Capitale to transmit such information to the aforementioned persons when necessary, within the scope of its activities and the processing of my file. Furthermore, I declare that all information provided in this application is true and complete, in the knowledge that any decision to issue a policy is based on this information."
This authorization is valid for the purposes of this policy and for any amendments, extensions or renewals thereof. A photocopy of this authorization is considered as valid as the original.

Participant's signature	Telephone	Date

(PLEASE READ THE NOTICE BELOW)

7- IDENTIFICATION OF ADVISOR (if any)

LAST NAME	FIRST NAME	CODE

NOTICE

La Capitale Insurance and Financial Services Inc. (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 Jacques-Parizeau St, P.O. Box 1500, Quebec QC G1K 8X9
Customer Service
Telephone: 418 644-4200 or Toll free: 1 800 463-4856

Please keep a copy of this form for your records.