



**La Capitale Civil Service Insurer Inc.**

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- MEMBERSHIP APPLICATION TO GROUP INSURANCE  
(COMPLETE 1-2-4-5-6-7)
- MODIFICATIONS TO GROUP INSURANCE  
(COMPLETE 1-2-3-4-6-7 AND 5 IF NECESSARY)
- SUBMITTED BY THE PORTAL

GROUP NO. <b>004500</b>	EMPLOYER NO.	IDENTIFICATION NO.
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<b>1- INFORMATION RELATING TO PARTICIPANT</b>		
NAME OF THE GROUP <b>F.M.R.Q.</b>	NAME OF THE EMPLOYER	EMPLOYEE NO.
FAMILY NAME	FIRST NAME	GENDER <input type="checkbox"/> M <input type="checkbox"/> F
NO. STREET	APT.	DATE OF BIRTH Y M D
ADDRESS		CORRESPONDENCE <input type="checkbox"/> E <input type="checkbox"/> F
CITY	POSTAL CODE	PHONE AT HOME
EMAIL ADDRESS <sup>1</sup>		PHONE AT WORK
CIVIL STATUS <input type="checkbox"/> SINGLE OR <input type="checkbox"/> MARRIED <sup>2</sup> <input type="checkbox"/> WIDOWED <sup>2</sup> <input type="checkbox"/> COMMON LAW SPOUSE <sup>2</sup> <input type="checkbox"/> DIVORCED <sup>2</sup> <input type="checkbox"/> SEPARATED <sup>2</sup> <input type="checkbox"/> CIVIL UNION <sup>2</sup>		TIME WORK <input type="checkbox"/> FULL <input type="checkbox"/> PARTIAL: _____ (%) OR _____ (WKLY/HRS)
NOTE 2: SINCE: Y M D	JOB TITLE	STATUS <input type="checkbox"/> PERMANENT <input type="checkbox"/> OTHER (SPECIFY): _____
ANNUAL SALARY	EMPLOYMENT DATE Y M D	ELIGIBILITY DATE Y M D

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

<b>2- COVERAGE(S)</b>	<b>APPLICATION</b>			<b>MODIFICATIONS<sup>3</sup></b>					
				<b>I ADD</b>			<b>I REMOVE</b>		
	<b>Basic plan</b>	<b>Intermediate plan</b>	<b>Superior plan</b>	<b>Basic plan</b>	<b>Intermediate plan</b>	<b>Superior plan</b>	<b>Basic plan</b>	<b>Intermediate plan</b>	<b>Superior plan</b>
<input type="checkbox"/> EXEMPTION <sup>4</sup> INDIVIDUAL PLAN	<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"/>
FAMILY PLAN	<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 3: You can change plan on July 1 of the year during which you are reaching the R3 level or when one of the life events specified in the contract occurs, provided the request for change is submitted within the 60 days following such event.									

<b>- PARTICIPANT'S LIFE INSURANCE</b>	<input checked="" type="checkbox"/>
<b>- DEPENDENT'S LIFE INSURANCE</b> (MANDATORY IF FAMILY STATUS)	<input type="checkbox"/>
<b>- LONG-TERM SALARY INSURANCE</b>	<input checked="" type="checkbox"/>

Note 4: TO BE EXEMPTED FROM HEALTH INSURANCE COVERAGES, THE EMPLOYEE MUST PROVIDE THE EMPLOYER WITH A COPY OF THE INSURANCE CERTIFICATE PROTECTING HIM OR HER AS A DEPENDENT PERSON FOR SIMILAR PROTECTION.

<b>3- MODIFICATIONS</b>	EFFECTIVE DATE Y M D
REASON(S) _____ <small>LEAVE OF ABSENCE, PARENTAL LEAVE, MATERNITY, TEMPORARY LAY OFF, BIRTH, MARRIAGE, DISABILITY, ETC.</small>	DATE OF RETURN (IF APPLICABLE) Y M D

<b>4- IDENTIFY YOUR DEPENDENTS</b>							
First name	Family name	Gender	Date of birth	First name	Family name	Gender	Date of birth
Spouse: _____	_____	<input type="checkbox"/> M <input type="checkbox"/> F	Y M D	Children: _____	_____	<input type="checkbox"/> M <input type="checkbox"/> F	Y M D
Children: _____	_____	<input type="checkbox"/> M <input type="checkbox"/> F	_____	_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F	_____
_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F	_____	_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F	_____

<b>5- BENEFICIARY'S FULL NAME (FOR LIFE INSURANCE COVERAGES)</b>	<b>ATTENTION: THE DESIGNATION OF AN IRREVOCABLE BENEFICIARY INVOLVES SIGNIFICANT CONSEQUENCES. HIS CONSENT WILL BE ABSOLUTELY NECESSARY IF YOU WANT TO REPLACE HIM AND, IF A MINOR, THE CONSENT OF HIS TUTOR WILL HAVE TO BE OBTAINED.</b>
DESIGNATION: _____	
RELATIONSHIP WITH THE PARTICIPANT: _____	MARK YOUR CHOICE <input type="checkbox"/> REVOCABLE <input type="checkbox"/> IRREVOCABLE

<b>6- AUTHORIZATION</b>
<p>"I hereby authorize my employer to deduct the required premiums from my salary, LaCapitale Civil Service Insurer Inc. (hereinafter mentioned La Capitale) and the person responsible for the plan to use my social insurance number for administration. Furthermore, I authorize any physician, any other professional and intervening party in the field of health and rehabilitation, as well as any public or private health or social services institution, any insurance company, as well as any reinsurer, any public or private organization, any information agency that will have received such a mandate, any market intermediary, any employer or ex-employer, the policyholder as well as any person holding personal files or information, especially medical records pertaining to me, as the case may be, to provide to LaCapitale or to its mandataries, any information that it holds, required for the processing of my file.</p> <p>I also authorize LaCapitale to transmit such information to the aforementioned persons when necessary, within the scope of its activities and the processing of my file.</p> <p>In the event of death, I specifically authorize the policyholder, the employer, the beneficiary, the heir or the liquidator of my succession to provide LaCapitale or its mandataries when necessary, with all information or authorizations permitting the processing of my file."</p> <p>This consent is valid for the purposes of this contract, its amendment, extension or renewal. A photocopy of this consent has the same value as the original.</p>
<p>Signature of the participant or, if under age, that of his or her legal representative _____ Phone number _____ Date _____</p> <p>(PLEASE CONSULT THE NOTICE ON THE BACK)</p>

<b>7- SIGNATURE OF THE EMPLOYER</b>
<p>_____ Phone number _____ Date _____</p>

White: insurer's copy – Yellow: employee's copy – Pink: employer's copy