La Capitale

La Capitale Civil Service Insurer Inc.
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☐ **GROUP INSURANCE APPLICATION**
☐ **MODIFICATION(S) TO GROUP INSURANCE**
☐ **REGISTRATION IN THE GROUP INSURANCE ADMINISTRATOR'S CENTRE**

Group No.	Employer No.	Identification No. (provided by the Insurer at the time of enrolment)
0 0 4 5 0 0		

1. INFORMATION ABOUT PARTICIPANT

Group name	Employer name	Employee No.	CMQ Permit No.
F.M.R.Q.			

Last name	First name	Date of birth (YYYY/MM/DD)	Sex	Language
			☐ F ☐ M	☐ English ☐ French

No., street, apt.	City	Province	Postal code

Email address[1]	Main phone Ext.	Phone (other) Ext.

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

Marital status
☐ single ☐ married or in a civil union ☐ common-law ☐ widowed ☐ divorced ☐ separated
As of (YYYY/MM/DD)

Employment date (YYYY/MM/DD)	Eligibility date (YYYY/MM/DD)	Employment status
		☐ Permanent ☐ Other:_____

Job title	Annual salary	Work schedule
		☐ Full-time ☐ Part-time:_____% or _____ hours/week

2. REASON(S) FOR MODIFICATION(S)

Reason: _____
Marriage, divorce, civil union, de facto separation, adoption, birth, death, etc.

Effective date of the event: _____
AAAA/MM/DD

3. COVERAGES

IMPORTANT : The information provided in this form must be interpreted in accordance with the contract provisions.

Health Insurance

Module selection[2]
☐ Basic coverage
☐ Standard coverage
☐ Extended coverage

Coverage status
☐ Individual
☐ Family

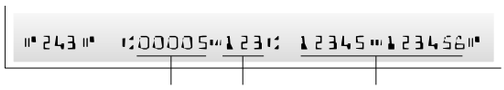
☐ Exemption[3]

	I want to apply	I want to remove
Participant's Life Insurance[4]		
– 1 x annual salary	☑	
Dependent's Life Insurance (Mandatory if family status)[5]		
– Spouse: $5,000 – Children[6]: $2,500	☐	☐
Long Term Disability Insurance	☑	

Note 2: A change of plan can be done on July 1 of the year in which R3 is attained or at the time of one of the life events provided for in the contract, provided that the application is submitted within 60 days following the event. | **Note 3**: IMPORTANT – To be exempt from enrolling in these insurance benefits, participants must provide the employer with proof of insurance under a group insurance contract with similar benefits for themselves and any dependents. | **Note 4**: The amount of insurance payable upon the participant's death is equal to 1 times the annual earnings payable on the date of death or on the date waiver of premiums began, if this date is earlier. | **Note 5**: Enrolment in this benefit is mandatory if the participant has a coverage status other than Individual for Health Insurance. | **Note 6**: At least 24 hours old.

☐ **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 bank information below. No cheque specimen is required).



Branch No. Institution No. Account No.

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4. INFORMATION ABOUT DEPENDENTS

	Full name	Sex F M	Date of birth (YYYY/MM/DD)	Dependent child with a functional impairment[7]	Complete this for a dependent child age 18 or over, who is a full-time student[8]	
					Start date of the semester (YYYY/MM/DD)	End date of the semester (YYYY/MM/DD)
Spouse		☐ ☐				
Children		☐ ☐		☐		
		☐ ☐		☐		
		☐ ☐		☐		
		☐ ☐		☐		

Note 7: Please contact customer service for how to proceed. | **Note 8:** La Capitale reserves the right to ask you for written proof of attendance from the institution at any time.

5. TERMINATION OF DEPENDENTS' COVERAGE

Please fill in Section 3 if you wish to change your coverage, and indicate the reason for this modification in Section 2.

Full name	Full name

6. BENEFICIARY DESIGNATION (for Life Insurance)

Revocable	Irrevocable	Full name	Percentage	Relationship to participant
☐	☐			
☐	☐			
☐	☐			

IMPORTANT NOTICE: If percentages are indicated, they must add up to a maximum of 100%. If percentages are not specified, the Life Insurance benefit will be equally shared among the designated beneficiaries. **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 right as a beneficiary. **PROVINCES OTHER THAN QUEBEC:** A beneficiary designation 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.

7. TRUSTEE DESIGNATION FOR A MINOR BENEFICIARY (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			
No, street, apt.	City	Province	Postal code

8. SIGNATURE OF EMPLOYER'S REPRESENTATIVE

X _____ Date: _____ Téléphone: _____

Signature YYYY/MM/DD

9. PARTICIPANT'S AUTHORIZATION

"I **hereby authorize** my employer to deduct the required premiums from my salary and **authorize** La Capitale and the plan administrator to use my social insurance number for administration purposes. 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 and social services institution, any insurance company, as well as any reinsurer, any public or private organization, any information agency, any market intermediary, any employer or ex-employer, the policyholder as well as any person holding personal files or information, particularly medical records, pertaining to me to provide to La Capitale or its service providers, any information that may be required for the processing of my file. This authorization is also valid, in the event of my death, with regard to any person or organization holding information required by La Capitale, or its service providers, that may be required for the processing of my file.

I **also authorize** La Capitale to transmit such information to the above-mentioned 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, the heir or the liquidator of my succession to provide La Capitale or its mandataries when necessary, with all information or authorizations permitting the processing of my file."

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

X _____ Date: _____

Participant's signature or, if a minor, signature of legal guardian YYYY/MM/DD

10. NOTICE

La Capitale wishes to advise you that the information collected will be kept in a file under the subject of "Group Insurance." Notwithstanding exceptions provided for by law, access to this file is restricted to employees, service providers of the company, on a need-to-know basis, as required to fulfil their duties or carry out their assignments. Your file will be kept at the address below.

You may access your file or request a correction for inaccurate or incomplete information by submitting a request in writing to the Information Access Officer in the Administration Department.

To serve its customers, La Capitale Financial Group Inc., its subsidiaries and authorized representatives may use your personal information (name, address, telephone number and email address) to inform you of products and services that may be of interest to you. If, however, you do not wish to receive this type of information, please write to us at the address below.

To contact our Customer Service:

Telephone: 418 644-4200
Toll Free: 1 800 463-4856
Email: adm.collectif@lacapitale.com

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This form may be sent to the Insurer by mail, fax or email, using the above contact information.
If you do not send the original document, store it in a safe place.
Please note that the Insurer may require the original document at any time for audit purposes.