La Capitale

☐ GROUP INSURANCE APPLICATION
(COMPLETE SECTIONS 1-2-4-5-6-7)

☐ MODIFICATION(S) TO GROUP INSURANCE
(COMPLETE SECTIONS 1-2-3-4-6-7 AND 5, IF APPLICABLE)

**La Capitale Insurance and Financial Services Inc.**
625 Jacques-Parizeau St, PO Box 1500, Quebec QC G1K 8X9
418 644-4200 or 1 800 463-4856 • Fax: 418 646-1313 • adm.collectif@lacapitale.com

| GROUP NO. | EMPLOYER NO. | IDENTIFICATION NO. |
|---|---|---|
| 009995 | | |

## 1- INFORMATION ABOUT PARTICIPANT

GROUP NAME: FÉDÉRATION AUTONOME DE L'ENSEIGNEMENT (teachers)

EMPLOYER NAME

EMPLOYEE NO. OR ID

LAST NAME | FIRST NAME | GENDER ☐ M ☐ F | DATE OF BIRTH Y M D

ADDRESS NO. STREET APT. | CORRESPONDENCE ☐ E ☐ F | HOME TEL. ( )

CITY | POSTAL CODE | WORK TEL. ( )

MARITAL STATUS
☐ SINGLE ☐ MARRIED* ☐ WIDOW(ER)* ☐ COMMON-LAW SPOUSE* ☐ DIVORCED* ☐ SEPARATED* ☐ CIVIL UNION*
*SINCE _____ Y M D

EMPLOYMENT STATUS
☐ FULL TIME
☐ PART TIME: _____ (% of full time)

EMPLOYMENT DATE Y M D | ELIGIBILITY DATE Y M D | ANNUAL SALARY $ _____ (As if 100% of full time)

## 2- PLANS

| | APPLICATION | MODIFICATION(S) ADD | MODIFICATION(S) REMOVE |
|---|---|---|---|
| **HEALTH INSURANCE PLAN** (mandatory) | | | |
| You must select only one of these plans: **HEALTH PLAN 1** | ☐ | ☐ | ☐ |
| **HEALTH PLAN 2** (minimum participation requirement: **12 months**) | ☐ | ☐ | ☐ |
| **HEALTH PLAN 3** (minimum participation requirement: **24 months**) | ☐ | ☐ | ☐ |
| ☐ INDIVIDUAL ☐ SINGLE-PARENT (no spouse) ☐ FAMILY ☐ EXEMPT[1] | | | |
| **ADDITIONAL PLAN 2 - LONG-TERM DISABILITY INSURANCE** (mandatory)[2] | ☐ | | ☐ |
| **- SHORT-TERM DISABILITY INSURANCE** (if provided under the contract) | ☐ | | |
| **ADDITIONNAL PLAN 3 - LIFE INSURANCE** (optional) | | | |
| - ***Participant's Life Insurance***[3] | | | |
| **$10,000**, $25,000, $50,000, $75,000, $100,000, $125,000 | | | |
| $150,000, $175,000, $200,000, $225,000 or $250,000 | | | |
| ☐ I exercice my right to opt when applying for the participant's mandatory life insurance amount of $10,000. | | | |
| ☐ SMOKER ☐ NON-SMOKER | _____ $ | _____ $ | _____ $ |
| - ***Dependents' Life Insurance*** | ☐ | ☐ | ☐ |
| - ***Spouse's Optional Life Insurance:*** 1 to 10 unit(s) of $10,000[4] | _____ x $10,000 | _____ x $10,000 | _____ x $10,000 |
| ☐ SMOKER ☐ NON-SMOKER | | | |

**NOTES:**
1. To be exempt from coverage under the Health Insurance plan, participants must provide the employer with proof of insurance under a group insurance plan with similar benefits.
2. To be exempt from coverage under the Long-Term Disability Insurance plan, participants must complete the *Exemption from Long-Term Disability Insurance* form and meet the conditions set out in the form.
3. The first $10,000 is automatically granted without evidence of insurability. The amounts of $25,000 and $50,000 are also available without evidence of insurability during the first 30 days after the eligibility date. After such time, and for all other amounts of coverage, evidence of insurability is required. Please complete the P007 *Declaration of Insurability* form.
4. Please complete the P007 *Declaration of Insurability* form.

## 3- MODIFICATION(S)

REASON FOR THE MODIFICATION _____
LEAVE WITHOUT PAY, PARENTAL OR MATERNITY LEAVE, TEMPORARY LAYOFF, BIRTH, MARRIAGE, ETC.

EFFECTIVE DATE OF THE EVENT Y M D

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

PLEASE:
A) ☐ MODIFY MY GROUP INSURANCE BENEFITS (PART 2)
B) ☐ MAINTAIN ALL MY GROUP INSURANCE BENEFITS
C) ☐ CANCEL ALL MY GROUP INSURANCE BENEFITS **EXCEPT** FOR MY PRESCRIPTION DRUG INSURANCE (PART 2)

## 4- INFORMATION ABOUT DEPENDENTS

| | First Name | Last name | Gender | Date of birth Y M D |
|---|---|---|---|---|
| Spouse: | | | ☐ M ☐ F | |
| Children: | | | ☐ M ☐ F | |
| | | | ☐ M ☐ F | |
| Children: | | | ☐ 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 WITH THE PARTICIPANT: _____

CHECK YOUR CHOICE
☐ REVOCABLE
☐ IRREVOCABLE

## 6- PARTICIPANT'S DECLARATION

I hereby agree to the provisions of the policy and consent to the required premiums being deducted from my salary, as applicable. I agree to my social insurance number being used for administrative purposes by La Capitale Insurance and Financial Services Inc. (La Capitale).

I authorize my employer, the policyholder, La Capitale or its reinsurers as well as its representatives, agents and mandataries to provide, receive and exchange any personal information regarding my eligibility, insurability and claims for benefits under the plan and those of my dependents, if applicable. In the event of death, I specifically authorize the policyholder, the employer, the beneficiary, the heir or the liquidator of my estate to provide to La Capitale, or its mandataries and agents, upon request, any information it may hold that may be 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 if used for the exchange of information.

_____ Signature of the participant or, if a minor, his or her legal representative

_____ – Telephone

_____ Date

(PLEASE READ THE NOTICE ON THE REVERSE)

## 7- SIGNATURE OF EMPLOYER'S REPRESENTATIVE

_____

_____ – Telephone

_____ Date



White copy: Insurer – Yellow copy: Employee – Pink copy: Employer

# ***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 Jacques-Parizeau St*
*P.O. Box 1500*
*Quebec QC  G1K 8X9*

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