La Capitale Civil Service Insurer Inc.
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418 644-4200 or 1 800 463-4856
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☐ **GROUP INSURANCE APPLICATION**
☐ **MODIFICATIONS TO GROUP INSURANCE**
☐ **REGISTRATION IN THE GROUP ADMINISTRATOR'S CENTRE**

Group No.	Employer No.	Class	Identification No. (provided by the Insurer at the time of application)

1. INFORMATION ABOUT PARTICIPANT

Employer name				Employee No.

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

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.

Civil Status — Since (YYYY/MM/DD)
☐ Single ☐ Married or civil union ☐ Common-law spouse ☐ Widowed ☐ Divorced ☐ Separated

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

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

2. REAISON FOR MODIFICATION

Reason: _____ Effective date of the event:
Marriage, divorce, civil union, dissolution of the civil union, adoption of a child, birth, death, etc.

3. COVERAGES

IMPORTANT: Mandatory coverages set out in the contract will automatically be granted. Please refer to the contract documents for coverages and provisions provided for under your group insurance contract.

☐ **HEALTH INSURANCE (may include vision care)**
Coverage status[2] : ☐ Individual ☐ Family ☐ Single-Parent ☐ Couple ☐ Exempt[3]

☐ **DENTAL CARE INSURANCE**
Coverage status[2] : ☐ Individual ☐ Family ☐ Single-Parent ☐ Couple ☐ Exempt[3]

☐ **HEALTH SPENDING ACCOUNT (HSA)**
Coverage status[2] : ☐ Individual ☐ Family ☐ Single-Parent ☐ Couple

☐ **PARTICIPANT'S BASIC LIFE INSURANCE (may include Accidental Death and Dismemberment)**

☐ **DEPENDENT'S LIFE INSURANCE[4]**

☐ **OPTIONAL LIFE INSURANCE[5]**
☐ Participant: $_____ ☐ Spouse: $_____ ☐ Dependent children: $_____

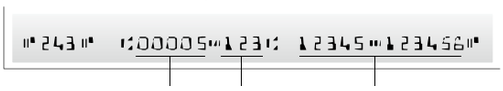
☐ **CRITICAL ILNESS INSURANCE**
☐ Participant ☐ Spouse ☐ Dependent children

☐ **SHORT-TERM DISABILITY INSURANCE**

☐ **LONG-TERM DISABILITY INSURANCE**

Note 2: Please refer to the contract documents for details of the available coverage status and the enrolment terms for each, if any. | **Note 3:** IMPORTANT – To be exempt from coverage under Health or Dental Care insurance, participants must provide the employer with proof of insurance under a group insurance plan offering similar benefits. | **Note 4:** When provided for in the contract, this benefit is mandatory when the participant holds a coverage status other than Individual for health care insurance, unless stipulated otherwise in the contract documents. | **Note 5:** These coverages are subject to the Insurer's approval of evidence of insurability. Please complete the *Declaration of Insurability* form and return it duly completed and signed.

☐ **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 following bank information; no cheque specimen is required).



Branch No. Institution No. Account No.

Branch No. Institution No. Account No.

4. INFORMATION ABOUT DEPENDENTS

	Full name	Gender F	Gender M	Date of birth (YYYY/MM/DD)	Dependent children with a functional impairment[6]	Fill this out for a dependent child over age 17 or 20 who is a full-time student[7]	
						Start date of the school year (YYYY/MM/DD)	End date of the school year (YYYY/MM/DD)
Spouse		☐	☐				
Children		☐	☐		☐		
		☐	☐		☐		
		☐	☐		☐		
		☐	☐		☐		

Note 6: Please contact customer service for how to proceed.

Note 7: Please check eligible age under your contract. La Capitale reserves the right to ask you for written proof from the institution attended at any time

5. WITHDRAWAL OF DEPENDENTS

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

Full name	Full name

6. BENEFICIARY DESIGNATION (for Life Insurance coverage)

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 may only be modified if the beneficiary is of legal age and provides written consent to the change.

7. DESIGNATION OF A TRUSTEE FOR 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. 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 aforementioned persons when necessary, within the scope of its activities and 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

9. SIGNATURE OF EMPLOYER'S REPRESENTATIVE

X _____ Date: _____ _____

Signature — Year Month Day — Telephone

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 and agents 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 ,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
Emai: adm.collectif@lacapitale.com

La Capitale Civil Service Insurer Inc.
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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, make sure you store it in a safe place.
Please note that the Insurer may require the original document at any time for audit purposes.