La Capitale

La Capitale Civil Service Insurer Inc.
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EMPLOYEES ON LEAVE OR ON LIGHT DUTIES ON THE DATE GROUP INSURANCE COMES INTO FORCE

To the policyholder: *This form must be completed without delay and sent to La Capitale Civil Service Insurer along with any necessary supporting documents. On receipt, La Capitale Civil Service Insurer Inc. will provide you with confirmation of the status of employees on leave or doing light duties on the date the group insurance comes into force. It is also* ***essential*** *that you send a copy of this form to your previous insurer.*

1. IDENTIFICATION OF POLICYHOLDER

Name: ______________________________

Group: ______________ Employer: ______________

Date on which the contract comes into force with La Capitale Civil Service Insurer Inc. (year-month-day): ______________

Name of previous insurer:

Contract number with the previous insurer ______________________________

2- DECLARATION

☐ **No** employees eligible for our plan are on maternity leave as at the effective date of the new contract, and **no** employees are on leave or doing light duties due to illness or accidental injury, nor on a gradual return to work.

☐ We have employees on maternity leave as at the effective date of the new contract, and/or have employees on leave or doing light duties due to illness or accidental injury, or on a gradual return to work. Please complete sections 3, 4 and 5 of this form.

Signature of plan administrator: ______________________ Date (year-month-day): ______________

3. INFORMATION CONCERNING THE WAIVER OF PREMIUMS

A. Coverages with waiver of premiums with the previous insurer

☐ Basic life ☐ Basic health ☐ Others, specify:

☐ Dependents' life ☐ Dental care ______________

☐ Optional life ☐ Short-term disability insurance ______________

☐ Accidental death or dismemberment ☐ Long-term disability insurance ______________

B. Waiting period to be eligible for waiver of premiums with your previous insurer

☐ 3 months ☐ 6 months ☐ Other, specify: ______________________________

4. INFORMATION CONCERNING EMPLOYEES ON LEAVE OR DOING LIGHT DUTIES

NOTE: PLEASE FILL OUT A SECOND FORM IF THE SPACE IS INSUFFICIENT AND ATTACH ALL CONFIRMATIONS OF DENIAL OF CLAIMS FOR WAIVER OF PREMIUMS FROM YOUR PREVIOUS INSURER.

A. Last name: ______________________ First name: ______________

Identification No.: ______________ Date of birth (year-month-day): ______________

Reason for leave or light duties: ☐ Illness ☐ CNESST ☐ SAAQ ☐ Retraite Québec

☐ Maternity leave ☐ Gradual return to own occupation ☐ Gradual return to different occupation

☐ Temporary layoff ☐ Full-time temporary assignment ☐ Gradual return to temporary assignment

☐ Leave without pay ☐ Other, specify: ______________________________

Date on which the disability began (year-month-day) ______________________________

Actual or expected date of return to work (year-month-day): ______________________________

Have you notified your previous insurer of this employee's disability? ☐ Yes ☐ No

Have you submitted an application for waiver of premiums to your previous insurer? ☐ Yes ☐ No

Was this employee eligible for a waiver of premiums with your previous insurer? ☐ Yes ☐ No

If so, since when (year-month-day): ______________________________

Employers may reproduce this form as needed.

4. INFORMATION CONCERNING EMPLOYEES ON LEAVE OR DOING LIGHT DUTIES

B. Last name: ______________________ First name: ______________________

Identification No.: ______________________ Date of birth (year-month-day): ______________________

Reason for leave or light duties: ☐ Illness ☐ CNESST ☐ SAAQ ☐ Retraite Québec

☐ Maternity leave ☐ Gradual return to own occupation ☐ Gradual return to different occupation

☐ Temporary layoff ☐ Full-time temporary assignment ☐ Gradual return to temporary assignment

☐ Leave without pay ☐ Other, specify: ______________________

Date on which the disability began (year-month-day) ______________________

Actual or expected date of return to work (year-month-day): ______________________

Have you notified your previous insurer of this employee's disability? ☐ Yes ☐ No

Have you submitted an application for waiver of premiums to your previous insurer? ☐ Yes ☐ No

Was this employee eligible for a waiver of premiums with your previous insurer? ☐ Yes ☐ No

If so, since when (year-month-day): ______________________

C. Last name: ______________________ First name: ______________________

Identification No.: ______________________ Date of birth (year-month-day): ______________________

Reason for leave or light duties: ☐ Illness ☐ CNESST ☐ SAAQ ☐ Retraite Québec

☐ Maternity leave ☐ Gradual return to own occupation ☐ Gradual return to different occupation

☐ Temporary layoff ☐ Full-time temporary assignment ☐ Gradual return to temporary assignment

☐ Leave without pay ☐ Other, specify: ______________________

Date on which the disability began (year-month-day) ______________________

Actual or expected date of return to work (year-month-day): ______________________

Have you notified your previous insurer of this employee's disability? ☐ Yes ☐ No

Have you submitted an application for waiver of premiums to your previous insurer? ☐ Yes ☐ No

Was this employee eligible for a waiver of premiums with your previous insurer? ☐ Yes ☐ No

If so, since when (year-month-day): ______________________

D. Last name: ______________________ First name: ______________________

Identification No.: ______________________ Date of birth (year-month-day): ______________________

Reason for leave or light duties: ☐ Illness ☐ CNESST ☐ SAAQ ☐ Retraite Québec

☐ Maternity leave ☐ Gradual return to own occupation ☐ Gradual return to different occupation

☐ Temporary layoff ☐ Full-time temporary assignment ☐ Gradual return to temporary assignment

☐ Leave without pay ☐ Other, specify: ______________________

Date on which the disability began (year-month-day) ______________________

Actual or expected date of return to work (year-month-day): ______________________

Have you notified your previous insurer of this employee's disability? ☐ Yes ☐ No

Have you submitted an application for waiver of premiums to your previous insurer? ☐ Yes ☐ No

Was this employee eligible for a waiver of premiums with your previous insurer? ☐ Yes ☐ No

If so, since when (year-month-day): ______________________

E. Last name: ______________________ First name: ______________________

Identification No.: ______________________ Date of birth (year-month-day): ______________________

Reason for leave or light duties: ☐ Illness ☐ CNESST ☐ SAAQ ☐ Retraite Québec

☐ Maternity leave ☐ Gradual return to own occupation ☐ Gradual return to different occupation

☐ Temporary layoff ☐ Full-time temporary assignment ☐ Gradual return to temporary assignment

☐ Leave without pay ☐ Other, specify: ______________________

Date on which the disability began (year-month-day) ______________________

Actual or expected date of return to work (year-month-day): ______________________

Have you notified your previous insurer of this employee's disability? ☐ Yes ☐ No

Have you submitted an application for waiver of premiums to your previous insurer? ☐ Yes ☐ No

Was this employee eligible for a waiver of premiums with your previous insurer? ☐ Yes ☐ No

If so, since when (year-month-day): ______________________

5. SIGNATURE

I declare that the information provided is accurate as of the date on which this form is signed.

______________________ ______________________

Date (year-month-day) Signature of plan administrator

Employers may reproduce this form as needed.