EXEMPTION

- ❑ Application for exemption
- ❑ Termination of exemption

La Capitale Civil Service Insurer Inc.
625 Jacques-Parizeau St, P.O. 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.

1 – INFORMATION ABOUT PARTICIPANT

LAST NAME / FIRST NAME		
NO. STREET / ADDRESS / APT.		HOME TEL.
TOWN/CITY	POSTAL CODE	WORK TEL.
DATE OF BIRTH (Year-Month-Day)	EMPLOYMENT DATE (Year-Month-Day)	

IMPORTANT: ALL APPLICATIONS MUST BE SUBMITTED WITHIN 30 DAYS FOLLOWING THE EVENT

2 – APPLICATION FOR EXEMPTION

Name of person insuring participant as a dependent: _____

Relationship to participant: _____

Name of employer through which this person is insured: _____

Name of insurer: _____

Reason for requesting exemption: _____

Eligibility date: _____

I hereby wish to waive coverage under the following insurance plan(s):

☐ Basic Health Insurance ☐ Complementary Health Insurance (if specified in contract ☐ Dental Care Insurance (if specified in contract)

as I have been insured since _____ as a participant or dependent under a group insurance contract containing similar benefits.

ENCLOSE A COPY OF YOUR INSURANCE CERTIFICATE FROM THE PREVIOUS INSURER SHOWING THE COVERAGE HELD

3 – TERMINATION OF EXEMPTION

Name and date of birth of individual(s) to be insured: _____

(other than participant): _____

Relationship to participant: _____

Name of previous insurer: _____

Is it **IMPOSSIBLE** for you to remain covered with the previous insurer? ☐ Yes ☐ No

If so, for which insurance benefits? _____

Reason for termination of coverage with previous insurer: _____

Date of termination of coverage with previous insurer: _____

Benefits held with previous insurer:

☐ Basic Health Insurance ☐ Complementary Health Insurance (if specified in contract) ☐ Dental Care Insurance (if specified in contract)

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4 – SIGNATURES

"I understand that any acceptance of my application by La Capitale Civil Service Insurer Inc. is subject to the provisions of the contract under which I am covered."

Signed at _____, on this _____ day of _____ 20 ____.

_____ Signature of participant

_____ Signature of witness (other than participant)

5 – SIGNATURE OF EMPLOYER

_____ Signature of employer

_____ Date

Employers may reproduce this form as their individual needs require.