La Capitale

TERMINATION OF EXEMPTION

La Capitale Civil Service Insurer 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.

1. INFORMATION ABOUT PARTICIPANT

Last name	First name	Date of birth (YYYY/MM/DD)

No., street, apt.	City

Province	Postal code	Main phone	Ext.	Phone (other)	Ext.

2. TERMINATION OF EXEMPTION

IMPORTANT: Applications must be submitted within 30 days following the event.

Name of previous insurer: ______________________________

Is it possible for you to remain insured by the previous insurer? ☐ Yes ☐ No

Reason for termination of coverage with the previous insurer: ______________________________

Termination date of coverage with the previous insurer: ______________________________

Benefits held with previous insurer: ☐ Basic Healh Insurance ☐ Dental Care Insurance (if included in the contract)

3. INFORMATION ABOUT DEPENDENTS

	Full name	Sex F M	Date of birth (YYYY/MM/DD)	Dependent child with a functional impairment[1]	Complete this for a dependent child over age 17 or 20, who is a full-time student[2]	
					Start date of the semester (YYYY/MM/DD)	End date of the semester (YYYY/MM/DD)
Spouse		☐ ☐				
Children		☐ ☐		☐		
		☐ ☐		☐		
		☐ ☐		☐		
		☐ ☐		☐		
		☐ ☐		☐		

Note 1: Please contact customer service for how to proceed.

Note 2: Please check the eligible age set out in your contract. La Capitale reserves the right to ask you for written proof of attendance from the institution at any time.

4. SIGNATURE OF PARTICIPANT

I declare that the information provided above is complete, true and in conformity with the terms and provisions of my group insurance contract. Any false declaration may result in the cancellation of the insurance.

I understand that my request for termination of exemption is conditional on approval by La Capitale Civil Service Insurer Inc., in accordance with the provisions of the contract under which I am covered.

Signed at ______________________, on this ________ day of ______________ 20 ______.

____
Signature of participant

5. SIGNATURE OF EMPLOYER'S REPRESENTATIVE

______________________________ ______________
Signature of representative Date

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.