La Capitale

EMPLOYEES ON LEAVE OR LIGHT DUTY ON THE EFFECTIVE DATE OF GROUP INSURANCE

To the Policyholder: This form must be promptly completed and sent to La Capitale Civil Service Insurer Inc. 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 light duty on the effective date of group insurance. 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 No. 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 light duty 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 light duty 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 WAIVER OF PREMIUMS

A. Benefits eligible for waiver of premiums with the previous insurer

☐ Short-Term Disability ☐ Long-Term Disability ☐ Accidental Death and Dismemberment

☐ Basic Health ☐ Dental Care ☐ Basic Life

☐ Dependents' Life ☐ Optional Life

☐ **Other, please indicate:** ____________________

B. Eligibility waiting period for waiver of premiums with the previous insurer

☐ 3 months ☐ 6 months

☐ **Other, please indicate:** ____________________

4. INFORMATION CONCERNING EMPLOYEES ON LEAVE OR LIGHT DUTY

IMPORTANT: 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 duty: ☐ Illness ☐ CNESST ☐ SAAQ

☐ Retraite Québec ☐ Maternity leave ☐ Leave without pay

☐ Gradual return to own occupation ☐ Full-time temporary assignment ☐ Gradual return to temporary assignment

☐ Gradual return to different occupation ☐ Temporary layoff

☐ Other, please specify: ____________________

Disability start date: ____________________
(year-month-day)

Scheduled or actual return-to-work date: ____________________
(year-month-day)

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

Have you submitted a request for waiver of premiums to your previous insurer? ☐ Yes ☐ No

Was this employee's premiums waived by your previous insurer? ☐ Yes ☐ No

If so, please indicate as of when: ____________________
(year-month-day)

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B. Last name: ______________________ First name: ______________________

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

Reason for leave or light duty: ☐ Illness ☐ CNESST ☐ SAAQ

☐ Retraite Québec ☐ Maternity leave ☐ Leave without pay

☐ Gradual return to own occupation ☐ Full-time temporary assignment ☐ Gradual return to temporary assignment

☐ Gradual return to different occupation ☐ Temporary layoff

☐ Other, please specify: ______________________

Disability start date: ______________________ (year-month-day)

Scheduled or actual return-to-work date: ______________________ (year-month-day)

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

Have you submitted a request for waiver of premiums to your previous insurer? ☐ Yes ☐ No

Was this employee's premiums waived by your previous insurer? ☐ Yes ☐ No

If so, please indicate as of when: ______________________ (year-month-day)

C. Last name: ______________________ First name: ______________________

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

Reason for leave or light duty: ☐ Illness ☐ CNESST ☐ SAAQ

☐ Retraite Québec ☐ Maternity leave ☐ Leave without pay

☐ Gradual return to own occupation ☐ Full-time temporary assignment ☐ Gradual return to temporary assignment

☐ Gradual return to different occupation ☐ Temporary layoff

☐ Other, please specify: ______________________

Disability start date: ______________________ (year-month-day)

Scheduled or actual return-to-work date: ______________________ (year-month-day)

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

Have you submitted a request for waiver of premiums to your previous insurer? ☐ Yes ☐ No

Was this employee's premiums waived by your previous insurer? ☐ Yes ☐ No

If so, please indicate as of when: ______________________ (year-month-day)

D. Last name: ______________________ First name: ______________________

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

Reason for leave or light duty: ☐ Illness ☐ CNESST ☐ SAAQ

☐ Retraite Québec ☐ Maternity leave ☐ Leave without pay

☐ Gradual return to own occupation ☐ Full-time temporary assignment ☐ Gradual return to temporary assignment

☐ Gradual return to different occupation ☐ Temporary layoff

☐ Other, please specify: ______________________

Disability start date: ______________________ (year-month-day)

Scheduled or actual return-to-work date: ______________________ (year-month-day)

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

Have you submitted a request for waiver of premiums to your previous insurer? ☐ Yes ☐ No

Was this employee's premiums waived by your previous insurer? ☐ Yes ☐ No

If so, please indicate as of when: ______________________ (year-month-day)

5. SIGNATURE

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

______________________ ______________________

Signature Date (YYYY-MM-DD)