AUTHORIZATION FOR THE DISCLOSURE OF MEDICAL INFORMATION

La Capitale Civil Service Insurer Inc.
625 Jacques-Parizeau St, PO Box 1500 Québec 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. AUTHORIZATION

TO THE ATTENTION OF THE MEDICAL DIRECTOR

I hereby authorize La Capitale Civil Service Insurer Inc. to communicate the reasons for the decision regarding my application for group insurance to the following physician.

Name of physician: _____

Address: _____

_____

_____

Postal code: _____

Insurance application for:

Name: _____

Date of birth: _____
(YYYY/MM/DD)

Address: _____

_____

_____

Postal code: _____

3. PARTICIPANT'S SIGNATURE

I declare that the information provided above is true and complete. I understand that any misrepresentation may result in the cancellation of my insurance.

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

Signature of participant _____

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.