**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

# INFORMATION CONCERNING DEPENDENTS

| 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. |
|---|---|---|---|---|---|
| | | | | | |

**Civil status**

- ☐ Single
- ☐ Married or in a civil union — Since: _____ (year-month-day)
- ☐ Common-law spouse — Date of cohabitation: _____ (year-month-day)
- ☐ Widowed — Since: _____ (year-month-day)
- ☐ Divorced — Since: _____ (year-month-day)
- ☐ Separated — Since: _____ (year-month-day)

## 2. INFORMATION ABOUT DEPENDENTS

**Spouse**

Last name, first name: _____

Date of birth: _____ (year-month-day) Sex: ☐ M ☐ F

| Child | Name of institution attended | Full-time student[1] or child with a functional impairment[2] |
|---|---|---|
| First name: _____<br>Last name: _____<br>Date of birth: _____ (year-month-day)<br>Sex: ☐ M ☐ F | _____ | ☐ Full-time student<br>From _____ to _____<br>☐ Functional impairment |
| First name: _____<br>Last name: _____<br>Date of birth: _____ (year-month-day)<br>Sex: ☐ M ☐ F | _____ | ☐ Full-time student<br>From _____ to _____<br>☐ Functional impairment |
| First name: _____<br>Last name: _____<br>Date of birth: _____ (year-month-day)<br>Sex: ☐ M ☐ F | _____ | ☐ Full-time student<br>From _____ to _____<br>☐ Functional impairment |

**Note 1:** Full-time student means four courses, 12 credits or 180 hours per session. The same criteria apply to correspondence courses offered by recognized institutions. | **Note 2:** Please contact customer service for how to proceed.

## 3. TERMINATION OF EXEMPTION FOR DEPENDENTS (if applicable)

Name of previous insurer: _____

Is it possible for the dependent(s) to remain insured by the previous insurer? ☐ Yes ☐ No Termination date of coverage: _____ (year-month-day)

Reason for termination of coverage: _____

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

## 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 for a dependent 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 (for termination of exemption requests only)

_____ _____
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.