

**La Capitale Insurance and Financial Services Inc.**  
625 Jacques-Parizeau St, P.O. Box 1500, Quebec QC G1K 8X9  
418 644-4200 ou 1 800 463-4856 • Fax: 418 646-1313 • adm.collectif@lacapitale.com

GROUP NO.	EMPLOYER NO.	IDENTIFICATION NO.
<b>009995</b>		

**1 – INFORMATION ABOUT THE PARTICIPANT**

LAST NAME		FIRST NAME			
ADDRESS	NO.	STREET	APT.	HOME TEL.	( )
TOWN/CITY	POSTAL CODE		WORK TEL.	( )	

**2 – WAIVER**

I, the undersigned, no longer wish to participate in the mandatory Long-Term Disability Insurance benefit, as I meet one of the following criteria:

- I am participating exclusively in the Teachers' Pension Plan (TPP), the Civil Service Superannuation Plan (CSSP) or the Pension Plan of Certain Teachers (PPCT);
- I am participating in the Government and Public Employees Retirement Plan (RREGOP) and have accumulated 33 or more years of service;
- I am age 53 or over;
- I am a member of a professional order and am covered under a similar benefit of a long term disability insurance plan provided by the order (enclose proof that such insurance is in force, along with a copy of the policy or insurance booklet);
- I have signed a retirement agreement (without the option of returning) and there are two years or less between the date of waiver and the date of retirement (enclose a copy of the agreement).

I understand that my Long Term Disability Insurance plan will end on the first pay period following the date this document is received by La Capitale Insurance and Financial Services Inc.

As such, I will have no recourse against my employer or La Capitale Insurance and Financial Services Inc. with regard to any claim whatsoever. Furthermore, I understand that in no case may I obtain coverage under this benefit in the future, even if I provide evidence of insurability.

**3 – SIGNATURES**

Signed at \_\_\_\_\_, on this \_\_\_\_\_ day of \_\_\_\_\_ 20 \_\_\_\_.

\_\_\_\_\_  
Signature of participant

\_\_\_\_\_  
Signature of witness

**4 – SIGNATURE OF EMPLOYER**

- I certify that the applicant is participating exclusively in the TPP, CSSP, or PPCT;  
or
- I certify that the applicant is participating in the Government and Public Employees Retirement Plan (RREGOP) and has accumulated 33 or more years of service;  
or
- I certify that the applicant is age 53 or over.

Signed at \_\_\_\_\_, on this \_\_\_\_\_ day of \_\_\_\_\_ 20 \_\_\_\_.

\_\_\_\_\_  
Signature

**Please return the original to the Insurer and keep a copy for your records.**

**Employers may reproduce this form as their individual needs require.**