La Capitale

11201

☐ GROUP INSURANCE APPLICATION
(COMPLETE SECTIONS 1-2-4-5-6-7)

☐ MODIFICATIONS TO GROUP INSURANCE
(COMPLETE SECTIONS 1-2-3-4-6-7 AND 5, IF APPLICABLE)

La Capitale Insurance and Financial Services Inc.
625 Saint-Amable 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.
6000		

1- INFORMATION ABOUT THE PARTICIPANT

GROUP NAME: FTQ INTERSECTORAL PARITY COMMITTEE | EMPLOYER NAME | EMPLOYEE NO. OR ID

LAST NAME | FIRST NAME | GENDER ☐ M ☐ F | DATE OF BIRTH Y M D

ADDRESS NO. STREET APT. | CORRESPONDENCE ☐ E ☐ F | HOME TEL. ( )

CITY | POSTAL CODE | WORK TEL. ( )

MARITAL STATUS
☐ SINGLE **OR** ☐ MARRIED* ☐ WIDOWED* ☐ COMMON-LAW SPOUSE* ☐ DIVORCED* ☐ SEPARATED* ☐ CIVIL UNION*
* SINCE: _____ Y M D

WORK ARRANGEMENT
☐ _____ FULL TIME
☐ PART TIME: _____ (%) OR _____ (WKLY/HRS)

JOB TITLE	ANNUAL SALARY	EMPLOYMENT DATE Y M D	ELIGIBILITY DATE Y M D	EMPLOYMENT STATUS
				☐ PERMANENT ☐ OTHER (SPECIFY): _____

2- PLAN(S)

	APPLICATION	MODIFICATIONS ADD	MODIFICATIONS REMOVE
■ **BASIC HEALTH INSURANCE (MANDATORY)**			
Select one: **COMPLETE TIER** (minimum participation requirement: **36 months**)	☐	☐	☐
Select one: **REDUCED TIER**	☐	☐	☐
INDIVIDUAL ☐ **SINGLE-PARENT (without spouse)** ☐ **FAMILY** ☐ **EXEMPTION*** ☐			
■ **OPTION 1 AND/OR 2**			
(Optional enrolment – minimum participation requirement: **36 months**)			
INDIVIDUAL ☐ **SINGLE-PARENT (without spouse)** ☐ **FAMILY** ☐			
- OPTION 1 EXTENDED HEALTH	☐	☐	☐
- OPTION 2 DENTAL CARE	☐	☐	☐
■ **OPTION 3– LIFE**			
- PARTICIPANT'S BASIC LIFE: 1 x annual salary (Mandatory for participation in the other Life Insurance benefits)	☐	☐	☐
- PARTICIPANT'S ACCIDENTAL DEATH AND DISMEMBERMENT: 1 x annual salary	☐	☐	☐
- SPOUSE'S OR DEPENDENT CHILDREN'S BASIC LIFE	☐	☐	☐
- PARTICIPANT'S OPTIONAL LIFE: ** 1 to 5 x annual salary ☐ Smoker ☐ Non-smoker	_____ x salary	_____ x salary	_____ x salary
- SPOUSE'S OPTIONAL LIFE: ** 1 to 20 units of $5,000 ☐ Smoker ☐ Non-smoker	_____ x $5,000	_____ x $5,000	_____ x $5,000

IMPORTANT: * To be exempted from coverage under the Basic Health Insurance plan, participants must provide the employer with proof of insurance under a group insurance plan offering similar benefits.

** These coverages are subject to the Insurer's approval of evidence of insurability. Please complete the Declaration of Insurability form (P015).

Note: To be eligible for Family or Single-Parent coverage under options 1, 2 or 3, you must have the same status under your basic plan, unless you have opted out. The participant's premiums are payable to the Insurer, even if there is no pay during the period. The Insurer may cancel the coverages within 30 days following the expiration date of all unpaid premiums.

3- MODIFICATION(S)

REASON(S) FOR CHANGE _____
OBTAINING A POSITION FOR THE FIRST TIME, LEAVE WITHOUT PAY, PARENTAL OR MATERNITY LEAVE, TEMPORARY LAYOFF, BIRTH, MARRIAGE, ETC.

PLEASE:
A) ☐ MODIFY MY GROUP INSURANCE PLANS (PART 2)
B) ☐ MAINTAIN ALL MY GROUP INSURANCE PLANS
C) ☐ CANCEL ALL MY GROUP INSURANCE PLANS **EXCEPT FOR** MY PRESCRIPTION DRUG INSURANCE PLAN (PART 2)

EFFECTIVE DATE OF THE EVENT Y M D

PLANNED DATE OF RETURN TO WORK (IF APPLICABLE) Y M D

4- IDENTIFY YOUR DEPENDENTS

	First name	Last name	Gender	Date of birth Y M D
Spouse:			☐ M ☐ F	
Child(ren):			☐ M ☐ F	
			☐ M ☐ F	
Child(ren):			☐ M ☐ F	
			☐ M ☐ F	
			☐ M ☐ F	

5- BENEFICIARY'S FULL NAME (FOR LIFE INSURANCE COVERAGE)

NOTE: DESIGNATING AN IRREVOCABLE BENEFICIARY CAN HAVE SIGNIFICANT CONSEQUENCES. TO REPLACE A BENEFICIARY DESIGNATED AS IRREVOCABLE, YOU MUST OBTAIN THE BENEFICIARY'S CONSENT AND, IF A MINOR, THE CONSENT OF THE BENEFICIARY'S LEGAL REPRESENTATIVE.

DESIGNATION: _____

RELATIONSHIP TO THE PARTICIPANT: _____

CHECK YOUR CHOICE
☐ REVOCABLE
☐ IRREVOCABLE

6- DECLARATION OF THE PARTICIPANT

I hereby agree to the provisions of the policy and consent to the required premiums being deducted from my salary, as applicable. I agree to my social insurance number being used for administrative purposes by La Capitale Insurance and Financial Services Inc. (La Capitale).

I authorize my employer, the policyholder, La Capitale or its reinsurers as well as its representatives, agents and mandataries to provide, receive and exchange between themselves any personal information regarding my eligibility, insurability and claims for benefits under the plan and those of my dependents, if applicable. In the event of death, I specifically authorize the policyholder, the employer, the beneficiary, the heir or the liquidator of my estate to provide to La Capitale, or its mandataries, upon request, any information it may hold that may be required for the processing of my file.

This authorization shall be valid for the purposes of this contract and for any amendments, extensions or renewals thereof. A photocopy of this authorization shall be considered as valid as the original if used for the exchange of information.

_____ ( ) – _____ _____
Participant's signature or if a minor, the legal representative — Telephone — Date

(PLEASE READ THE NOTICE ON THE REVERSE)

7- SIGNATURE OF EMPLOYER'S REPRESENTATIVE

_____ ( ) – _____ _____
Telephone — Date

White copy: insurer – Yellow copy: employee – Pink copy: employer

N O T I C E

La Capitale Insurance and Financial Services Inc. (hereafter La Capitale), wishes to advise you that information collected during this transaction will be kept in a file under the subject of “Group Insurance”. Access to this file is restricted to employees and agents of the company, on a need-to-know basis, as required to fulfil their duties or carry out their assignments. Notwithstanding exceptions provided for by law, no other person may access your file without your authorization. Your file will be kept at the address below.

You may access your file by submitting a request in writing to the information Access Officer in the Administration Department. If any of your personal information is inaccurate, incorrect or incomplete, you may submit a request in writing to have it corrected.

When you take out a contract with La Capitale, your name and address are included in our client database to help us provide you with quality service and information on new products designed to meet your needs. If you would prefer to have your contact details removed from our distribution list, please call or write to let us know.

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Customer Service
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or
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