La Capitale

fneeq CSN
Fédération nationale des enseignantes et des enseignants du Québec

ENROLMENT FORM FOR MODULAR PLANS

La Capitale Insurance and Financial Services Inc.
625 Saint-Amable St, PO Box 1500, Quebec QC G1K 8X9
Telephone: 1 855 747-7819 • Fax: 418 646-1313

GROUP NO.	EMPLOYER NO.	IDENTIFICATION NO.

SECTION 1 – PARTICIPANT PERSONAL INFORMATION

PLEASE CHECK, CORRECT OR COMPLETE THE INFORMATION BELOW

Name: ____________________

Address: ____________________

____

Postal code: ____________ Language preference: ☒ E ☐ F

Date of birth: ____________ (Year Month Day) Gender: ☐ F ☐ M

Marital status: ☐ Single **OR** ☐ Married ☐ Common-law union ☐ Divorced ☐ Separated ☐ Civil union, since ____________ (Year Month Day)

SECTION 2 – COVERAGE

		CURRENT COVERAGE	COVERAGE AS OF JANUARY 1, 2013		
• **HEALTH INSURANCE (mandatory)** Note: The coverage plan selected for Health Insurance will also apply to Dental Care Insurance, if applicable.			**BASIC (Module A)**	**STANDARD (Module B)**	**EXTENDED (Module C)**
Coverage plan	Individual	☐	☐	☐	☐
	Single-Parent (no spouse)	☐	☐	☐	☐
	Couple (no eligible children)	☐	☐	☐	☐
	Family	☐	☐	☐	☐
	Exemption[1]	☐	☐		

	CURRENT COVERAGE	COVERAGE AS OF JANUARY 1, 2013	
• **DENTAL CARE INSURANCE (optional)** Note: Extended coverage (Option 2) is only available when extended coverage (Module C) is selected for Health Insurance.	☐	**BASIC (Option 1)** ☐	**EXTENDED (Option 2)** ☐
• **PARTICIPANT'S BASIC LIFE INSURANCE (INCLUDING CRITICAL ILLNESS INSURANCE OF $25,000)[2] (optional)** - Active participant **under age 65**	☐ 2 x the annual salary minimum $20,000	☐ **1 x the annual salary**, minimum $35,000 Participants who select 1 x the annual salary for Basic Life Insurance coverage may not retain or add additional units of life insurance. ☐ **2 x the annual salary**, minimum $70,000	
- Active participant **age 65 or over**	**No change** **Current coverage maintained on January 1, 2013**		
To enrol in Dependents' Life Insurance and Participant's and Spouse's Optional Life Insurance, Participant's Basic Life Insurance must be selected. • **DEPENDENTS' LIFE INSURANCE (optional)[2]**	☐	**Addition** ☐	
• **PARTICIPANT'S OPTIONAL LIFE INSURANCE (optional)[2]** - Active participant **under age 65** *Participants must hold Basic Life Insurance of 2 x the annual salary to enrol in Optional Life Insurance.*	____units of $20,000 No change will be made to amounts held before January 1, 2013	From 1 to 10 units of $25,000 **Addition of**_____ units of $25,000	
• **SPOUSE'S OPTIONAL LIFE INSURANCE (optional)[2]** - Active participant **under age 65** *Dependents' Life Insurance coverage must be selected to enrol in Spouse's Optional Life Insurance.*	____units of $20,000 No change will be made to amounts held before January 1, 2013	From 1 to 10 units of $25,000 **Addition of**_____ units of $25,000	

[1] To be exempt from Health Insurance coverage, participants must provide proof to the employer that they are insured under another group insurance plan with similar coverage.

[2] This coverage is subject to the Insurer's acceptance of evidence of insurability in the case of any addition or increase of coverage. Please complete the P007-A Declaration of Insurability form available on the FNEEQ's website.

SECTION 3 – DEPENDENTS' PERSONAL INFORMATION (IF FAMILY, COUPLE OR SINGLE-PARENT PLAN)

		Gender	Date of birth			Gender	Date of birth
Spouse:	____________	☐ M ☐ F	________ Year Month Day	Child:	____________	☐ M ☐ F	________ Year Month Day
Child:	____________	☐ M ☐ F	________ Year Month Day	Child:	____________	☐ M ☐ F	________ Year Month Day

SECTION 4 – BENEFICIARY'S FULL NAME (COMPLETE ONLY IN THE CASE OF INCREASED LIFE INSURANCE)

ATTENTION: Designating an irrevocable beneficiary can have significant consequences. To replace a beneficiary designated as irrevocable, you must obtain the beneficiary's consent, or, if a minor, the consent of the beneficiary's legal guardian.

CHECK YOUR CHOICE

Designated beneficiary: ____________________ ☐ REVOCABLE

Relation to the participant: ____________________ ☐ IRREVOCABLE

SECTION 5 – PARTICIPANT'S DECLARATION

"I authorize my employer to deduct from my salary the required premiums for the coverage I have selected. I authorize my employer and La Capitale Insurance and Financial Services to use the information contained in this application, including my Social Insurance No., for administrative purposes.

I certify that all information entered in this application is accurate and complete. Furthermore, I acknowledge having read and retained a copy of the notice concerning personal information and files that is found on the back of this form."

____________________ (______) ____________ ____________

Participant's signature or if a minor, the legal guardian — Telephone — Date

PLEASE READ THE NOTICE ON THE REVERSE

SECTION 6 – SIGNATURE OF EMPLOYER'S REPRESENTATIVE

____________________ (______) ____________ ____________

Telephone — Date

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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or
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