La Capitale

RETURN THIS FORM TO:
AQRP
5400 des Galeries Blvd, Suite 111, Quebec QC G2K 2B4
Telephone: 418 683-2288 • Toll free: 1 800 653-2747
Fax: 418 683-9567 • secretariat@aqrp.qc.ca

INDIVIDUAL HEALTH INSURANCE APPLICATION

☐ INSURANCE APPLICATION
☐ MODIFICATION(S) TO INSURANCE

Policy No. 0 0 3 9 9 7

AQRP member No.

Reserved for La Capitale	
	Identification No.

1. INFORMATION ABOUT THE POLICYHOLDER

Last name | First name | Gender ☐ M ☐ F

Language of correspondence ☐ English ☐ French | No., street, apt. | City

Province | Postal code | Telephone | Date of birth (Year Month Day)

Email address

Civil status
☐ Single ☐ Married or civilly united[1] ☐ Common-law spouse[1] ☐ Widowed[1] ☐ Divorced[1] ☐ Separated[1] **Note 1:** Since (Year Month Day)

2. INFORMATION ABOUT THE PREVIOUS CONTRACT OR CURRENT CONVERSION PRODUCT

☐ I am or was insured under a group health insurance plan.

Contract No.: _____ Insurer: _____

Identification No., if insured by La Capitale: _____ Contract termination date: (Year Month Day)

If your insurer was not La Capitale Civil Service Insurer Inc. (La Capitale), attach a document that demonstrates you were covered by a group health insurance plan and also includes the contract termination date and the name of each insured. If you submit your application more than 60 days after the contract termination date, please complete the Declaration of Insurability form and attach it to this form.

☐ I was not insured under an insurance contract during the last 60 days. Complete the Declaration of Insurability form for each proposed insured.

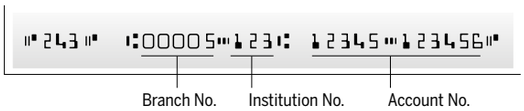
3. CHOICE OF COVERAGE

I choose: ☐ Individual coverage ☐ Family coverage[2]

Note 2: – If dependents are or were insured under a contract other than the one indicated in Section 2, attach proof of coverage held if it ended within the last 30 days.
– If dependents were not insured under any contracts indicated in Section 2 or if they were insured under an insurance contract that terminated more than 30 days ago, they must complete the Declaration of Insurability form and attach it to this form.

☐ **DIRECT DEPOSIT SERVICE FOR REIMBURSEMENT OF HEALTHCARE EXPENSES**

I authorize La Capitale to deposit my health insurance and/or dental care insurance benefits in my bank account. (Please complete the following bank information; no cheque specimen is required).



Branch No. | Institution No. | Account No.

4. REASONS FOR MODIFICATION

_____ Effective date of the event: (Year Month Day)

5. INFORMATION ABOUT DEPENDENTS

	Full name	Gender M F	Date of birth (YY/MM/DD)	Child with a functional impairment[3]	Fill this out for a dependent child over age 18 who is a full-time student[4]	
					Start date of the school year (YY/MM/DD)	End date of the school year (YY/MM/DD)
Spouse		☐ ☐				
Children		☐ ☐		☐		
		☐ ☐		☐		
		☐ ☐		☐		
		☐ ☐		☐		

Note 3: Please contact customer service for how to proceed.
Note 4: La Capitale reserves the right to ask you for written proof from the institution attended.

6. METHOD OF PREMIUM PAYMENT

☐ **Preauthorized Debit Agreement (PAD) – Personal** (If this method of premium payment is selected, please attach a cheque specimen)

Debit characteristics – This is a variable amount PAD. You, as the payor, authorize La Capitale to debit from the bank account indicated the amounts required for payment of the premium plus taxes and any charges applicable to your insurance policy. Your preauthorized payment frequency will correspond to your billing frequency. The preauthorized payment will take place 15 days following the production of your invoice.
You also authorize La Capitale to carry out a redraw within 10 days in the event that a preauthorized payment does not clear the account. In such case, an administration fee may be applied.

Waiver – I hereby waive the right to be notified regarding:
1) Authorization before the first payment is processed,
2) Subsequent payments, and
3) Changes to the amount or date of the preauthorized payment initiated by me or by the company.

Cancellation – I may revoke my authorization by providing 30 days' notice. To obtain a sample PAD cancellation form, or for more information about my right to cancel a PAD, I may contact my financial institution or visit www.payments.ca
I understand that the Insurer may terminate this agreement by providing 30 days' written notice.

Recourse and reimbursement – I agree to contact La Capitale in the event that a PAD is disputed.
You have certain recourse rights if any debit does not comply with this agreement. For example, you have the right to receive reimbursement for any debit that is not authorized or is not consistent with this PAD. To obtain information on your recourse rights, you may contact your financial institution or visit www.payments.ca.

X _____ Date: ____ ____ ____ (Year Month Day)
Signature of account holder

X _____ Date: ____ ____ ____ (Year Month Day)
Signature of second account holder, if required

☐ ***Retraite Québec***
(If you are a retired Quebec public or parapublic sector employee, the payment may be debited from your pension benefits.) As the recipient of benefits from *Retraite Québec*, I authorize this organization to deduct the required contributions from my pension cheque until I give notice otherwise.

X _____ Date: ____ ____ ____ (Year Month Day) _____
Signature of contributor — Social Insurance No. (SIN) (Mandatory for enrolling in this method of payment)

☐ **I would like monthly billing** (payment by cheque)

X _____ Date: ____ ____ ____ (Year Month Day)
Signature of account holder

7. POLICYHOLDER'S AUTHORIZATION

"I authorize La Capitale to use my Social Insurance Number for administration purposes. Furthermore, I **authorize** any physician, any other professional and any intervening party in the field of health and rehabilitation, as well as any public or private health and social services institution, any insurance company, as well as any reinsurer, any public or private organization, any information agency, any market intermediary, any employer or ex-employer, as well as any person holding personal files or information, particularly medical records pertaining to myself, as the case may be, to provide to La Capitale or its service providers, any information that may be required for the processing of my file. This authorization is also valid, in the event of my death, with regard to any person or organization holding information required by La Capitale, or its service providers, that may be required for the processing of my file.

I also **authorize** La Capitale to transmit such information to the aforementioned persons when necessary, within the scope of its activities and the processing of my file."

This authorization is valid for the purposes of this policy and for any amendments, extensions or renewals. A photocopy of this authorization is considered as valid as the original.

X _____ Date: ____ ____ ____ (Year Month Day) _____
Signature of policyholder — Telephone

8. NOTICE

La Capitale wishes to advise you that the information collected will be kept in a file under the subject of "Group Insurance." Notwithstanding exceptions provided for by law, access to this file is restricted to employees and service providers of the company, on a need-to-know basis, as required to fulfil their duties or carry out their contracts. Your file will be kept at the address below.

You may access your file or request a correction for inaccurate or incomplete information by submitting a request in writing to the Information Access Officer in the Administration Department.

To serve its customers, La Capitale Financial Group Inc., its subsidiaries and authorized representatives may use your personal information (name, address, telephone number and email address) to inform you of products and services that may be of interest to you. If, however, you do not wish to receive this type of information, please write to us at the address below.

To contact our Customer Service:

Telephone: 418 644-4200
Toll free: 1 800 463-4856
Email: adm.collectif@lacapitale.com

La Capitale Civil Service Insurer Inc.
625 Jacques-Parizeau St, PO Box 1500
Quebec QC G1K 8X9
lacapitale.com

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, make sure you store it in a safe place.
Please note that the Insurer may require the original document at any time for audit purposes.

C3997-0A (11-2018)