La Capitale Insurance and Financial Services Inc.
418 644-4200 or 1 800 463-4856 • Fax: 418 646-1313
adm.collectif@lacapitale.com

☐ APPLICATION ☐ MODIFICATION(S)

RETURN THIS FORM TO:
AQRP, 5400 Des Galeries Blvd, Suite 111
Quebec QC G2K 2B4

POLICY NO.		AQRP MEMBER NO.	IDENTIFICATION NO.
005844			

1- INFORMATION ABOUT PARTICIPANT

NAME OF GROUP: ASSOCIATION QUÉBÉCOISE DES RETRAITÉ(E)S DES SECTEURS PUBLIC ET PARAPUBLIC

LAST NAME			FIRST NAME
DATE OF BIRTH Y M D	GENDER ☐ M ☐ F	TELEPHONE ( ) -	CITY
ADDRESS NO. STREET APT.			POSTAL CODE

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

2- IF COVERED BY GROUP LIFE INSURANCE IN THE PAST 60 DAYS AND WISHING TO TRANSFER COVERAGE WITHOUT EVIDENCE OF INSURABILITY
(Evidence of insurability will be required for any additional amount)**:**

☐ Date insurance terminated: ______________________
or
☐ I will terminate my insurance upon receipt of notice from the insurer that my transfer request has been accepted. Insurance will become effective on the first day of the month following the date the Insurer receives the request and evidence of current coverage.

In both cases, enclose a copy of recent documents confirming this insurance coverage (contract number, amount of insurance). The amount transferred will be rounded up to the nearest $5,000, without however exceeding the maximum permitted for the participant's age under the contract.

IF NOT COVERED BY GROUP LIFE INSURANCE IN THE PAST 60 DAYS OR IF A TRANSFER OF THE COVERAGE AMOUNT IS NOT DESIRED:

Complete the Declaration of Insurability form for each of the proposed insureds. This application is conditional on approval by La Capitale.

3- COVERAGE REQUESTED (✓)

				APPLYING	ADDING	REMOVING
PARTICIPANT'S LIFE INSURANCE	• IF UNDER AGE 75:	1 TO 16 UNITS OF $5,000	____	☐	☐	☐
	• IF AGE 75 OR OVER:	1 TO 8 UNITS OF $5,000	____	☐	☐	☐
DEPENDENT'S LIFE INSURANCE				☐	☐	☐

4- MODIFICATIONS

REASON(S) ____

EFFECTIVE DATE Y M D

DATE OF RETURN (IF APPLICABLE) Y M D

5- BENEFICIARY

***Attention:** 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 guardian.*

DESIGNATED BENEFICIARY: ______________________________________ ☐ REVOCABLE ☐ IRREVOCABLE

RELATIONSHIP TO PARTICIPANT: ______________________________________

6- METHOD OF PREMIUM PAYMENT

A. ☐ **CARRA**
As the recipient of benefits from the *Commission administrative des régimes de retraite et d'assurances (CARRA)*, I authorize this organization to deduct the required contributions monthly from my pension cheque until I give notice otherwise.

Social Insurance Number (SIN): ______________________
MANDATORY for selection of this method of payment

Participant's signature: ______________________ Date: ______________________

B. ☐ **ANNUAL INVOICE**
Participant's signature: ______________________ Date: ______________________

C. ☐ **PREAUTHORIZED DEBIT AGREEMENT – TYPE OF PAD: Personal**
Bank account information: Please attach a cheque specimen.

I, the undersigned, authorize La Capitale Insurance and Financial Services Inc. (La Capitale) to debit the bank account printed on the enclosed cheque specimen the fixed monthly amounts required for the payment of premiums payable to La Capitale. Payment will be debited on the 15th of every month.

Signature(s) according to requirements
for withdrawals from this account: ______________________ Date: ______________________

You will receive notice at least ten (10) days prior to the first PAD confirming the amount and date of PADs. This agreement may be cancelled upon receipt by La Capitale of thirty (30) days' written notice prior to the scheduled date of the next PAD. Furthermore, 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 PAD that is not authorized or is not consistent with this agreement.

To obtain a sample PAD cancellation form, or for more information about your right to cancel this agreement and your rights to recourse, contact La Capitale or visit the website, www.cdnpay.ca.

7- AUTHORIZATION AND DECLARATION

"I hereby authorize La Capitale Insurance and Financial Services Inc. (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 that may receive such a mandate, 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 agents or mandataries, any information 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. Furthermore, I declare that all information provided in this application is true and complete, in the knowledge that any decision to issue a policy will be based on this information."

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

______________________ ______________________
Participant's signature Date

(PLEASE READ THE NOTICE ON THE REVERSE)

White copy: AQRP – Yellow copy: AQRP – Pink copy: retiree

C5844-0A (2015-11-02)

NOTICE

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.

La Capitale Insurance and Financial Services Inc.
625 Saint-Amable St.
P.O. Box 1500
Quebec QC G1K 8X9

Customer Service
Telephone: 418 644-4200
or
Toll free: 1 800 463-4856