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va acques-Parizeau St, PO Box 1500, Québec QC G1K 8X9 i44-4200 or 1 800 463-4856 : adm.collectif@beneva.ca	☐ REGISTRATION IN THE GROUP INSURANCE ADMINISTRATOR'S CENTRE
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☐ GROUP INSURANCE APPLICATION ☐ MODIFICATION(S) TO GROUP INSURANCE

18 644-4200 or 1 800 463-4856 mail: adm.collectif@beneva.ca		ADMIN	ISTRATO	KS CENT	KE			
Group No.	mployer No.	Identifica	tion No. (provid	ed by the Insur	er at the time of enro	lment)		
0 0 1 0 8								
. INFORMATION ABOUT PARTICIPAL	NT							
Group name	Employer name				Employee's No.			
FNEEQ - CSN (CÉGEPS)			- In		1/DD) 1 0			
Last name	First name		Date of bil	th (YYYY/MI	M/DD) Sex	F English		
Apt. No., street		City		F	Province Postal code			
Email address <sup>1</sup>		Main phone	Ex	ct. F	Phone (other)	Ext.		
Note 1: By giving my email address, I consent to receiving	ng only documents that con	cern my group insu	ırance.					
Marital status  ☐ single ☐ married or in a civil union [	common-law	widowed  div	vorced 🗌 s	separated	Since (YYYY/MM/I	DD) 		
	e (YYYY/MM/DD)	Employment statu		· <u> </u>		<u> </u>		
Current title	Annual salary ac	cording to the % of		schedule				
	\$	-	□ Fu	II-time	☐ Part-ti	me:%		
Were you insured under the FNEEQ contact prior today	?	☐ Yes	☐ No	1	Termination date (	YYYY/MM/DD)		
If so, indicate employer's name:								
Reason:  Marriage, temporary layoff, de facto separation,			Effective da	ate of the evo	ent:			
B. BENEFITS								
IMPORTANT: The information provided in this for	m must be interpreted in	accordance with	n the contrac	t provisions				
Health Insurance – Mandatory								
-	- 3 ( 1		[	☐ Exemp	tion <sup>3</sup>			
Dental Care Insurance								
Option 1: Basic coverage								
				Enroll	Add	Remove		
Participant's Basic Life Insurance and C	ritical Illness Insura	nce <sup>5, 6 and 7</sup>						
<ul> <li>1 times the annual salary (minimum \$75,000)<sup>8</sup></li> <li>2 times the annual salary (minimum \$75,000)<sup>8</sup></li> <li>Active participant age 70 and over (\$10,000)</li> </ul>								
Dependents' Life Insurance <sup>6, 7 and 9</sup>								
<ul> <li>Spouse under age 65: \$10,000</li> <li>Spouse age 65 or over: \$5,000</li> <li>Dependent child: \$5,000</li> </ul>								
Optional Life Insurance <sup>10</sup>			<u> </u>					
- Participant: 1 to 10 units of \$25,000 - Spouse: 1 to 10 units of \$25,000				units units	units			
Long-Term Disability Insurance <sup>11</sup>								

Note 2: Minimum participation period of 12 months before increasing and of 36 months before decreasing. Furthermore, any coverage change request must be filled between November 1 and 30 of each year. The coverage change will come into effect on January 1 of the following year. | Note 3: IMPORTANT – To be exempt from these benefits, participants must provide the employer with proof of insurance under a group insurance contract with similar benefits for themselves and any dependents. | Note 4: The coverage plan must be the same for Health Insurance, except when the exemption entitlement is exercised for the Health Insurance benefit | Note 5: Participation in this benefit is mandatory for enrolling in other Life Insurance benefits and coverage of two times the annual salary is required for enrolling in Participants Optional Life Insurance. The maximum lifetime amount payable under Critical Illness Insurance is \$25,000, subject to contract provisions. | Note 6: The Insurer pays the beneficiary the life insurance amount corresponding to the age of the participant at the time of death. | Note 7: No evidence of insurability is required to enrol in these benefits within 30 days of the date of eligibility or 30 days following the event. After this period, evidence of insurability is required at all times. | Note 8: The insurance amount is reduced by 50% at age 65. | Note 9: Required to enroll in Spouse's Optional Life Insurance. | Note 10: Evidence of insurability is required at all times. | Note 11: Mandatory participation for permanent employees and any teaching staff working in a college on the contract start date who have three years of seniority as of the first eligible contract, subject to the exemption entitlement.

#### 4. INFORMATION ABOUT DEPENDENTS

	Full name	Sex F M	Date of birth (YYYY/MM/DD)	Dependent	Complete this for a deper over, who is a full-	
Spouse				child with a functional impairment <sup>12</sup>	Start date of the semester (YYYY/MM/DD)	End date of the semester (YYYY/MM/DD)
Children						
Note 12: Pleas	e contact customer service for how to proceed.   Note 13: La Capitale re	eserves the	right to ask you for writt	ten proof of attenda	ance from the institution at any tir	me.

TERMINATION			

Please fill in Section 3 if you wish to change your coverage, and indicate the reason for this modification in Section 2.

Full name	Full name

### 6. BENEFICIARY DESIGNATION (for Life Insurance benefits)

Revocable	Irrevocable	Full name	Percentage	Relationship to participant

**IMPORTANT NOTICE:** If percentages are indicated, they must add up to a maximum of 100%. If percentages are not specified, the Life Insurance benefit will be equally shared among the designated beneficiaries. **PROVINCE OF QUEBEC:** Designating a legally married or civilly united spouse as a beneficiary is considered irrevocable unless stipulated otherwise by the participant. Any irrevocable beneficiary designation may only be modified if the beneficiary is of legal age and signs a waiver of his or her right as a beneficiary. **PROVINCES OTHER THAN QUEBEC:** A beneficiary designation is considered revocable unless stipulated otherwise by the participant. Any irrevocable beneficiary designation may only be modified if the beneficiary is of legal age and provides written consent to the change.

#### TRUSTEE DESIGNATION FOR A MINOR BENEFICIARY (does not apply in Quebec)

If you designate a beneficiary who has not reached the age of majority, you must name a trustee.

Full name			
No, street, apt.	City	Province	Postal code

#### 8. PARTICIPANT'S AUTHORIZATION

"I hereby agree to the provisions of the group insurance contract and consent to the required premiums being deducted from my salary, as applicable. I agree to the use of my social insurance number for administrative purposes by La Capitale Civil Service Insurer Inc. (La Capitale)

I authorize my employer, the Policyholder, La Capitale or its reinsurers as well as its representatives and its service providers 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 service providers, any information it may hold that may be required for the processing of my file."

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

$\chi$	Date:
Participant's signature or, if a minor, signature of legal guardian	YYYY/MM/DD
SIGNATURE OF EMPLOYER'S REPRESENTATIVE	

# 9.

<u>X</u>	Date:					$\perp$	
Signature		Year	Month	Day	Telephone		

## 10. NOTICE

La Capitale wishes to advise you that the 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 service providers 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

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.

To contact our Customer Service: Telephone: 418 644-4200

625 Jacques-Parizeau St. PO Box 1500 Toll free: 1 800 463-4856 Quebec QC G1K 8X9 • beneva.ca Email: adm.collectif@beneva.ca

This form may be sent to the Insurer by mail or email, using the above contact information. If you do not send the original document, store it in a safe place Please note that the Insurer may require the original document at any time for audit purposes.