Beneva
625 Jacques-Parizeau St., PO BOX 1500, Quebec QC G1K 8X9
418 644-4200 or 1 800 463-4856
Email: adm.collectif@beneva.ca

☐ **GROUP INSURANCE APPLICATION**
☐ **MODIFICATION TO GROUP INSURANCE**
☐ **REGISTRATION IN THE GROUP ADMINISTRATOR'S CENTRE**

Group No.	Employer No.
1 0 3 0 0 0	

Identification No. (provided by the Insurer at the time of application)

1. INFORMATION ABOUT PARTICIPANT

Group name	Employer name	Employee No
FÉDÉRATION INTERPROFESSIONNELLE DE LA SANTÉ DU QUÉBEC		

First name	Last name	Date of birth (YYYY/MM/DD)	Gender	Language
			☐ F ☐ M	☐ English ☐ French

Apt.	No., Street	City	Province	Postal Code

Email address[1]	Main phone Ext.	Phone (other) Ext.

Note 1: By giving my email address, I consent to receiving only documents that concern my group insurance.

Civil status
☐ Single ☐ Married or civil union ☐ Common-law spouse ☐ Widowed ☐ Divorced ☐ Separated
Since (YYYY/MM/DD)

Employment date (YYYY/MM/DD)	Eligibility Date (YYYY/MM/DD)	Status
		☐ permanent ☐ temporary ☐ other: _____

Job title	Annual salary	Work schedule
	$_____	☐ Full-time ☐ Part-time: _____% or _____ hours/week

2. REASON FOR MODIFICATION

Effective date of the event (Year / Month / Day)

☐ Life event (birth, marriage, etc.): _____

☐ Review of % of time worked

Please place a check mark beside the changes you would like to make to your insurance plans, in section 3 below.

3. PLAN

Health Insurance Plan - Mandatory

Module selection[2]
☐ Bronze
☐ Silver
☐ Gold
☐ Exemption[3]

Participant status
☐ Individual
☐ Single-Parent (no spouse)
☐ Family

Minimum participation requirement: **24 months[4]**

Dental Care Plan

Participant status[5]
☐ Individual
☐ Single-Parent (no spouse)
☐ Family
☐ I wish to end my participation in the Dental Care Plan

Minimum participation requirement: **36 months**

	I want to apply	I want to add	I want to remove
Life Insurance Plan			
Participant's Basic Life (includes Participant's Basic AD&D) – Amount: $5,000	☑	n/a	n/a
Spouse's and Dependent Children's Life[6] – Spouse: $3,000 – Dependent children: $3,000	n/a	☐	☐
Participant's Optional Life (maximum $100,000) (includes Participant's Optional AD&D) **Select the desired amount of insurance for this benefit[7]:** ☐ $5,000 ☐ $10,000 ☐ $15,000 ☐ $25,000 ☐ $50,000 ☐ $75,000 ☐ $100,000 ☐ None			
Participant's Optional Life ($125,000 or more) [8 and 9] – 1 to 16 units of $25,000[10] No. of units:	_____	_____	_____
Spouse's Optional Life[9] – 1 to 20 units of $25,000[10] No. of units:	_____	_____	_____
Long-Term Disability Insurance Plan	☑	n/a	n/a

Note 2: Employees who do not have permanent full-time employee status, or 70% or more of full-time status, will automatically be assigned the Bronze module after one month of continuous service. The module selection of these employees will be applied at the end of the waiting period for all plans, i.e. after three months of continuous service. | **Note 3:** To take advantage of their exemption entitlement, salaried employees must establish that they and their dependents are covered under another group insurance plan with similar benefits. | **Note 4:** This period must be completed before an alternate module associated with a decrease in coverage may be selected. An alternate module associated with an increase in coverage may be selected at any time. | **Note 5:** The participant status selected for the dental care plan may be different from the one selected for the health insurance plan. Please refer to the contract for details of the available participant status combinations. **Note 6:** Participation in this benefit is **mandatory** for those whose participant status is other than Individual for the Health Insurance Plan. | **Note 7:** If the request is made within the 30-day period following the initial date of eligibility for this benefit, evidence of insurability is required for any excess over $75,000. Following the expiry of this period, evidence of insurability is required for any subsequent amount of insurance. | **Note 8:** To enrol in this benefit, participants must have $100,000 of Participant's Optional Life (maximum: $100,000). | **Note 9:** Includes vested rights. | **Note 10**: Evidence of insurability is required at all times.

4. INFORMATION ABOUT DEPENDENTS

	Last name	First name	Gender F M	Date of birth (YYYY/MM/DD)	Dependent child with a functional impairment[11]	Fill this out for a dependent child age 18 or over, who is a full-time student[12]	
						Start date of the school year (YYYY/MM/DD)	End date of the school year (YYYY/MM/DD
Spouse			☐ ☐				
Children			☐ ☐		☐		
			☐ ☐		☐		
			☐ ☐		☐		
			☐ ☐		☐		
			☐ ☐		☐		

Note 11: Please contact customer service for how to proceed.
Note 12: La Capitale reserves the right to ask you for written proof from the institution attended at any time.

5. WITHDRAWAL OF DEPENDENTS

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

Full name	Full name

6. BENEFICIARY DESIGNATION (for Life Insurance Plan)

Revocable	Irrevocable	Full name	Percentage	Relationship to participant
☐	☐			
☐	☐			
☐	☐			

IMPORTANT NOTICE: If percentages are indicated, they must add up to 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 may only be modified if the beneficiary is of legal age and provides written consent to the change.

7. DESIGNATION OF A TRUSTEE (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 authorize** my employer to deduct the required premiums from my salary and **authorize** La Capitale and the plan administrator 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, the policyholder as well as any person holding personal files or information, particularly medical records, pertaining to me 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 contract and for any amendments, extensions or renewals. A photocopy of this authorization is considered as valid as the original.

X _____ Date : _____ _____

Participant's signature or, if a minor, signature of legal guardian — Year Month Day — Telephone

9. SIGNATURE OF EMPLOYER'S REPRESENTATIVE (section reserved for human resources)

X _____ Date: _____ _____

Signature — Year Month Day — Phone

10. NOTICE

The Insurer undertakes to collect and use participant's personal information only to the extent of its relevance to this contract. The Insurer undertakes to take reasonable security safeguards to ensure the protection of the personal information collected, used, disclosed, retained or destroyed, in keeping with its sensitivity, the purposes for which it is to be used, its quantity, distribution and medium.

In this regard, only its representatives, mandataries, agents, subcontractors, reinsurers, employees, principals, officers, administrators, directors, associates and successors, and any other person who is responsible with, for or toward it, and the persons whom the insured has authorized and those who are authorized by law, will have access to the personal information of the participant. They will have such access only to the extent required for the performance of their duties or the carrying out of their assignments.

The disclosure of a participant's personal information to a third party must be done with the Policyholder's prior explicit consent, in accordance with the provisions set out in *An Act respecting the Protection of Personal Information in the Private Sector* and the *Civil Code of Quebec*.

To contact our Customer Service:
Telephone: 418 644-4200
Toll free: 1 800 463-4856
Email: adm.collectif@beneva.ca

Beneva
625 Jacques-Parizeau St, PO Box 1500
Quebec QC G1K 8X9 • 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, 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.

Beneva designates La Capitale Civil Service Insurer Inc. as insurer.

C103000-0A (2025-02)