



11204

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GROUP NO.	EMPLOYER NO.
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A- NAME OF PARTICIPANT (MAIDEN NAME, IF APPLICABLE)		FIRST NAME		IDENTIFICATION NUMBER	
ADDRESS	NO.	ST.	APT.	CITY	POSTAL CODE
TELEPHONE NUMBERS HOME: () - OFFICE: () -			CURRENT POSITION (employment)	ARE YOU CURRENTLY WORKING? <input type="checkbox"/> Yes <input type="checkbox"/> No	IF NOT, EXPLAIN WHY.

B- TO BE FILLED BY THE PARTICIPANT IN ALL CASES (INDIVIDUAL OR FAMILY PROTECTION)

HAVE ANY OF THE PEOPLE TO BE INSURED:

1) ALREADY BEEN INSURED UNDER THE DENTAL CARE PLAN? Yes No

IF SO, UP TO WHAT DATE: _____ / _____ / _____ REASON FOR TERMINATION: _____
year month day First name

C- FOR EACH PERSON TO BE INSURED, PROVIDE THE FOLLOWING INFORMATION:

	FIRST NAMES	DATE OF BIRTH	DATE OF THE MOST RECENT COMPLETE CHECK-UP BY THE DENTIST, DENTUROLOGIST OR SPECIALIST	DATE OF THE MOST RECENT TREATMENT BY THE DENTIST, DENTUROLOGIST OR SPECIALIST	NAME AND ADDRESS OF THE DENTIST, DENTUROLOGIST OR SPECIALIST
PARTICIPANT					
SPOUSE					
CHILD					
CHILD					
CHILD					

D- THE PEOPLE TO BE INSURED: (FOR YES ANSWERS, EXPLAIN BELOW)

	PARTICIPANT		THE SPOUSE		THE CHILDREN	
	YES	NO	YES	NO	YES	NO
1) HAVE THEY CONSULTED FOR DENTAL EXAMINATIONS OR CARE OVER THE PAST TWO (2) YEARS?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2) HAVE THEY BEGUN A DENTAL TREATMENT THAT STILL IS NOT COMPLETED?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3) WILL THEY RECEIVE DENTAL CARE DURING THE NEXT SIX(6) MONTHS?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4) HAVE THEY BEEN INFORMED BY THEIR DENTIST OR DENTUROLOGIST OR SPECIALIST OF DENTAL CARE TO COME?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5) WILL THEY HAVE TO INSURE A DENTURE <input type="checkbox"/> FULL OR <input type="checkbox"/> PARTIAL DATE OF LAST CHANGE: _____ / _____ / _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

EXPLANATION OF YES ANSWERS:

QUESTION NO.	FIRST NAME	THE DENTAL CARE AND TREATMENT		NAME AND ADDRESS OF THE DENTIST DENTUROLOGIST OR SPECIALIST
		IN PROGRESS	UPCOMING	

E- STATEMENT

«I hereby state that the aforementioned answers are complete and true, and recognize that in the event the application is accepted, it will be governed by the conditions of a contract for each of the aforementioned persons to be insured. In addition I know that the insurance issued hereunder will only come into force for any or all of the aforementioned persons on the day that La Capitale Insurance and Financial Services Inc. will approve it and will inform the applicant of its decision in writing.» This application will be considered as refused if it does not receive the approval of the head office of the La Capitale Insurance and Financial Services Inc. within 60 days following the date it has been completed. In addition, any misrepresentation may be reason for canceling the insurance.

Signed in _____ on _____ / _____ / _____
month day year

_____ spouse _____ participant

F- AUTHORIZATION

«I hereby authorize any physician, dentist, healthcare professional and provider in the health and rehabilitation sectors as well as any public or private health institution or social services, insurance company and/or reinsurer, public or private organization, information bureau which has been mandated, any insurance broker, employer or ex-employer, the policyholder and any other person holding files or personal information, particularly medical information on me and my spouse and dependents if applicable to provide to La Capitale Insurance and Financial Services Inc. (hereinafter mentioned La Capitale) or its agents, any information, necessary for processing my file.

I also authorize La Capitale to provide information to the aforementioned persons for the processing of my file, if necessary.

In the event of death, I expressly authorize the policyholder, employer, beneficiary, legal heir or the liquidator of my estate to provide La Capitale or its agents when required, any information or authorizations needed for processing my file.»

This consent is valid for purposes of this insurance contract, for its modification, extension or renewal. A photocopy of this authorization is as valid as the original.

If you applied to the family protection we require the consent of your spouse and your dependents over 18 years old.

Proposed insured signature or legal representative if a minor _____ date _____ Spouse's signature _____ date _____

Signature of dependent age 18 years old and over _____ date _____ Signature of dependent age 18 years old and over _____ date _____