La Capitale

INVOLUNTARY LOSS OF EMPLOYMENT
INSURED'S STATEMENT

Insured's last name

Insured's first name

Date of birth: Year Month Day

Sex: ☐ F ☐ M

Contract No.

Client No.

1 Insured's occupation: _____

2 Name and telephone number of employer: _____ Area code Telephone No.

3 Employed by this employer since: Year Month Day

4 Last day worked: Year Month Day

5 When was the insured informed of the loss of employment? Year Month Day

6 Number of hours per week worked for this employer: _____

7 Was the employment:

Temporary? ☐ Yes ☐ No
Contract work? ☐ Yes ☐ No
Part-time? ☐ Yes ☐ No
Seasonal? ☐ Yes ☐ No
Permanent? ☐ Yes ☐ No

8 Was the position held within the insured's own business? ☐ Yes ☐ No

9 Was the insured on strike at the time employment was lost? ☐ Yes ☐ No

10 Was the insured previously absent from work for more than 14 consecutive days due to an illness or an accident? ☐ Yes ☐ No

If so, from Year Month Day to Year Month Day

11 Names and addresses of employers previous to this employment:

Name and address of employer	Start of employment	End of employment
	Year Month Day	Year Month Day
	Year Month Day	Year Month Day
	Year Month Day	Year Month Day

La Capitale Civil Service Insurer Inc.
625 Jacques-Parizeau St, Quebec QC G1R 2G5

IND230E (04-2020)

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12 Additional information: _____

_____

_____

_____

INSURED'S STATEMENT

I acknowledge and agree that the answers given in this form are true and complete.

Signed at _____ on this _____ day of _____ 20 _____ .

_____
Signature of insured

_____ _____
Address (No., street, apt., city, province) Postal code

_____ _____
Area code Home tel.

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