La Capitale

GROUP INSURANCE CONVERSION

Participant's last name ____________ Participant's first name ____________

Group: ______ Employer: ______ Identification No.: ______

1 Regarding the conversion privilege provided for under my contract, I wish to convert the following:

- ☐ Life insurance
- ☐ Health insurance
- ☐ Dental Care insurance

2 Date of termination of employment: ______ (Year Month Day)

3 Reason for termination of employment:

____

____

____

4 Do you have another job? ☐ Yes ☐ No

If so, specify the amount of your new group insurance coverage: ______________________________

____

Signed at ______________________________ on this ______ day of ______________ 20 ______ .

Participant's signature

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

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