

625 Jacques-Parizeau St PO Box 1500, Quebec QC G1K 8X9 Fax: 418 643-7323 or 1 855 669-8830 Email: collectif_deces@lacapitale.com

Group No.

Claim

Critical illness insurance Stroke

Need help completing this form? Call us at 418 644-4200 or 1 800 463-4856.

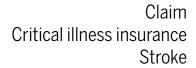
You can download a printable version of this form from La Capitale's website at lacapitale.com/forms

1.	INFORMATION ABOUT THE PARTICIPANT												
	Last name	First name				Gender □ M □ F							
	No. and street		City										
	Province		'	Postal code		Home t	el.						
2.	INFORMATION ABOUT THE CLAIMANT												
	Last name	First name						Gende					
	Year Month Day Year Month Day	ent child											
	Address, if different from that of the participant No. and street												
	Province	Home t	el.										
	PLEASE NOTE THAT CLAIMANTS MUST HAVE THE ATTENDO COMPLETED BY THEIR PHYSICIAN AND ARE RESPONSIBLE				N THE REV	ERSE S	SIDE OF THIS	FORM					
3.	AUTHORIZATION												
	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 that may receive such a mandate, any market intermediary, any employer or ex-employer, the policyholder as well as any person holding persona files or information, particularly medical records pertaining to myself, not including genetic test results, and any of my dependents, to provide to La Capitale Civil Service Insurer Inc. or its mandataries, any information held 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 you have applied for Family coverage status, the authorization	n of your spouse a	and de	pendent ch	ildren age 1	8 or ove	er is also requi	red.					
	Participant's signature or, if a minor, signature of legal guardian					Date:	Year	Month	Day				
	X Chausala signatura					Date:	Vaar	Month	Day				
	Spouse's signature						Year	Month	Day				
	Dependent's signature if age 18 or over					Date:	 Year	Month	Day				
	X					Date:							
	Dependent's signature if age 18 or over						Year	Month	Day				

IMPORTANT NOTE: When disclosing medical and health information, the results of any genetic test should not be included.

Identification No.

Employer No.





4.1	When did the insured first become a patient of yours? Year Month Day							
4.2	When did your patient's symptoms first occur?							
4.3	What did they consist of?							_
4.5	What is the date of the first consultation with regard to this condition? Year Month Day Has the patient experienced paralysis or other neurological deficits? No Yes If so, what are the neurological sequelae?							_
4.7 4.8 4.9	Are the neurological sequelae temporary or permanent? ☐ Temporary ☐ Permanent	Jay Bay	; W	eeks (or mor	nths le	ading ι	
4.10	Does your patient have any risk factors for stroke? Yes No Since when? Medication Hypertension							_ _ _
4.11	Year Month Day Please enter the name of any other physician whom the insured has consulted or any hospital where for this condition or a related one:	the ins	sure	ed ha	s recei	ved tre	eatmer	nt —
spe Our Are	ase provide us with any other information that you believe would be pertinent to analyzing this claim cialist or hospital reports for use by our medical director. contract requires that the diagnosis of a covered illness be made by a physician who is not a relative or a you a relative or a business associate of the insured? Yes No				-		-	ı
K Phys	ician's signature	_ Date:	L	Y	l l 'ear	Mon	th Day	
 Phys	sician's name (please print)	_ Licer	nce	No.				_



625 Jacques-Parizeau St PO Box 1500, Quebec QC G1K 8X9 Fax: 418 643-7323 or 1855 669-8830 Email: collectif_deces@lacapitale.com

Claim

Critical illness insurance Cancer

Need help completing this form? Call us at 418 644-4200 or 1 800 463-4856.

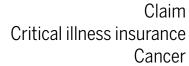
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1	INFORMATION ABOUT THE PARTICIPANT									
	Last name First name	Gender □ M □ F								
	No. and street	City								
	Province	Postal code								
2.	INFORMATION ABOUT THE CLAIMANT									
	Last name First name	Gender □ M □ F								
	Date of birth									
	Address, if different from that of the participant No. and street	City								
	Province	Postal code								
	PLEASE NOTE THAT CLAIMANTS MUST HAVE THE ATTENDING PHYSICIAN COMPLETED BY THEIR PHYSICIAN AND ARE RESPONSIBLE FOR ANY FEE									
3.	AUTHORIZATION									
	I authorize any physician, any other professional and any intervening party in the health and social services institution, any insurance company, as well as any rethat may receive such a mandate, any market intermediary, any employer or exfiles or information, particularly medical records pertaining to myself, not inclu La Capitale Civil Service Insurer Inc. or its mandataries, any information held the This authorization is valid for the purposes of this contract and for any amendrations and the original.	nsurer, any public or private organization, any information agency employer, the policyholder as well as any person holding personal ding genetic test results, and any of my dependents, to provide to at may be required for the processing of my file.								
	If you have applied for Family coverage status, the authorization of your spouse	and dependent children age 18 or over is also required.								
	X Participant's signature or, if a minor, signature of legal guardian	Date: Year Month Day								
	X Spouse's signature	Date: Year Month Day								
	<u>X</u>	Date:								
	Dependent's signature if age 18 or over	Year Month Day								
	Dependent's signature if age 18 or over	Date: U								
	September Subjustition ago to or ordi	ioai montii bay								

IMPORTANT NOTE: When disclosing medical and health information, the results of any genetic test should not be included.

Identification No.

Employer No.





4.

AT	TENDING PHYSICIAN'S STATEME	NT (Please print)									
4.1	1.1 When did your patient's symptoms first occur?										
4.2	What did they consist of?	Year Month Day									
4.3	On what date did your patient first consult you for this condition? Year Month Day										
4.4	When did the insured first become a patient of yours? Year Month Day										
4.5	On what date was this cancer diagnosed?										
4.6	On what date was the patient informed of the	e diagnosis? Year Month Day									
	By whom?	·									
4.8	Please provide a copy of the pathology report Type of tumor	ort and specify the following:									
	Location of tumorClinical stageHistology and classification	T N	М								
4.9	Please enter the names and addresses of other	physicians whom your patient consulted or hospitals who	ere the patient was treated for this cancer:								
	Name	Address	Period								
4.10	Has your patient previously suffered from ca If so, please provide the dates and pertinent in	ncer or from any health problem that might have cont nformation:	ributed to this illness? No Yes								
4.11	Has your patient undergone an HIV screening	g test? Yes, on Year Month Day	o □ Don't know								
	If so, what were the results?										
4.12	Does the patient have a family history of can If so, please provide details in that regard: _	cer? □ No □ Yes									
	Please include information on any other sign	ificant family history:									
4.13	Please provide us with any other information	that you believe would be pertinent to analyzing this	claim:								
	use provide copies of any specialist or hospit		or a husiness associate of the incured								
Our		ed illness be made by a physician who is not a relative	or a business associate of the insured.								
Our Are	contract requires that the diagnosis of a cover you a relative or a business associate of the ins	ed illness be made by a physician who is not a relative	Date:								
Our Are	contract requires that the diagnosis of a cover you a relative or a business associate of the ins	ed illness be made by a physician who is not a relative obured? Yes No	Date:								
Our Are	contract requires that the diagnosis of a cover you a relative or a business associate of the ins	ed illness be made by a physician who is not a relative obured? Yes No	Date:								



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Claim

Critical illness insurance Heart attack (myocardial infarction)

Need help completing this form? Call us at 418 644-4200 or 1 800 463-4856.

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IME	PORTANT NOTE: When disclosing medical and health information, the results of any genetic test should not be included.										
	Group No. Employer No. Identification No.										
1.	INFORMATION ABOUT THE PARTICIPANT										
	Last name First name Gender ☐ M ☐ F										
	No. and street City										
	Province Postal code Home tel.										
2.	INFORMATION ABOUT THE CLAIMANT										
	Last name First name Gender										
	Date of birth										
	Address, if different from that of the participant										
	No. and street City										
	Province Postal code Home tel.										
3.	PLEASE NOTE THAT CLAIMANTS MUST HAVE THE ATTENDING PHYSICIAN'S STATEMENT ON THE REVERSE SIDE OF THIS FORM COMPLETED BY THEIR PHYSICIAN AND ARE RESPONSIBLE FOR ANY FEES CHARGED. AUTHORIZATION										
	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 that may receive such a mandate, 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 myself, not including genetic test results, and any of my dependents, to provide to La Capitale Civil Service Insurer Inc. or its mandataries, any information held 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 you have applied for Family coverage status, the authorization of your spouse and dependent children age 18 or over is also required.										
	Participant's signature or, if a minor, signature of legal guardian Date:										
	Dependent's signature if age 18 or over Date: Year Month Day Dependent's signature if age 18 or over Year Month Day Dependent's signature if age 18 or over Year Month Day										
4.	ATTENDING PHYSICIAN'S STATEMENT (Please print)										
	4.1 a) On what date did your patient first consult you for this condition? Year Month Day										
	b) When did the insured first become a patient of yours? Year Month Day										



Claim Critical illness insurance Heart attack (myocardial infarction)

4. ATTENDING PHYSICIAN'S STATEMENT (cont.)

4.2	a) Was a diagnosis of myocardial infarction made? \square No \square Yes		
	b) If so, when was the diagnosis made?		
	Year Month Day c) By whom?		
	Please provide the names and addresses of other physicians who were consulted or hospitals to v this illness:	which the patient was admitted for	
4.3	Please provide the following details pertaining to your patient's heart attack: a) Description of chest pain:		
	b) Date of onset of symptoms: Year Month Day c) Electrocardiographic changes at the time of the attack or copies of pertinent ECG tracings:		
	d) Details of changes in myocardial marker enzymes at the time of the attack:		
4.4	Details of any other investigations (dates and reports):		
	Date: Year Month Day Date: Year Month Day Year Month Day		
4.5	When did your patient first experience symptoms or episodes of cardiovascular disease? (Details and	d dates)	
	Date: Year Month Day		
	Date: Year Month Day		
4.6	Please describe and provide dates for any of the patient's risk factors for cardiovascular disease, incl	uding genetic predisposition:	
4.7	Do you know if any of the patient's family members have suffered from this condition or a similar conprovide details:	ndition? □ No □ Yes - If so, please	
4.8	Please provide details concerning tobacco use (number of cigarettes smoked per day or date on which	ch the patient quit smoking):	
4.9	Please provide us with any other information that you believe would be pertinent to analyzing this cla	nim:	
Our	se provide copies of any specialist or hospital reports for use by our medical director. contract requires that the diagnosis of a covered illness be made by a physician who is not a relative or a rou a relative or a business associate of the insured? Yes No	business associate of the insured.	
X	out a foliative of a pasificas associate of the insured: 🗀 165 🗀 140	Data: .	
	cian's signature	_ Date:	
Physi	cian's name (please print)	Licence No.	01-2020)
THE	CLAIMANT IS RESPONSIBLE FOR ANY FEES CHARGED FOR THE COMPLETION OF THIS FORM.	Page 2 of 2	P1033E (01-2020)



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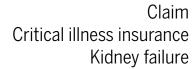
Claim

Critical illness insurance Kidney failure

Need help in completing this form? Call us at 418 644-4200 or 1 800 463-4856.

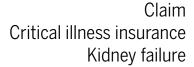
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IMF	PORTANT NOTE: When disclosing medical and health information	, the results of an	/ gen	etic test sh	ould not be	include	ed.		
	Group No. Employer No.	Identification No.							
	Group No.								
<u>1.</u>	INFORMATION ABOUT THE PARTICIPANT								
	Last name	First name						Gende	
									I □ F
	No. and street		City						
	Province			Postal code	Ι	Home to	el. , ,	1 .	
2.	INFORMATION ABOUT THE CLAIMANT								
	Last name	First name						Gende	er
									l □ F
		claim concerns the:							
		Participant 🗆 Spo	ouse	☐ Depend	dent child				
	Year Month Day Year Month Day Address, if different from that of the participant								
	No. and street		City						
			,						
	Province			Postal code	1	Home to	el.		
	PLEASE NOTE THAT CLAIMANTS MUST HAVE THE ATTENDI	NG PHYSICIAN'S	STAT	TEMENT O	N THE RE\	/ERSE S	IDE OF THI	S FORM	
	COMPLETED BY THEIR PHYSICIAN AND ARE RESPONSIBLE	FOR ANY FEES C	HAR	GED.					
3.	AUTHORIZATION								
<u>. </u>	AOTHORIZATION								
	I authorize any physician, any other professional and any interventealth and social services institution, any insurance company, a								
	that may receive such a mandate, any market intermediary, any	employer or ex-er	nploy	er, the poli	cyholder as	s well as	any person	holding p	ersonal
	files or information, particularly medical records pertaining to n La Capitale Civil Service Insurer Inc. or its mandataries, any info	nyself, not includin	g ger	netic test re	sults, and a	any of m	y dependent	s, to prov	ide to
	This authorization is valid for the purposes of this contract and		-	•	·		•	authoriza	tion ic
	considered as valid as the original.	ior arry arriendinier	113, 6	XIGHSIOHS C	i renewais.	. A prioto	copy or triis	autiioiiza	11101115
	If you have applied for Family coverage status, the authorization	of your spouse ar	ıd de _l	pendent ch	ildren age 1	18 or ove	er is also req	uired.	
	X					Date:	1	1.	
	Participant's signature or, if a minor, signature of legal guardian					_ Date.	Year	Month	Day
							I	1	í I
	X Spouse's signature					_ Date:	Year	Month	Day
	opouse 3 signature						icai	WOTTETT	Duy
	X					_ Date:			\perp
	Dependent's signature if age 18 or over						Year	Month	Day
	X					Date:	, , ,		
	Dependent's signature if age 18 or over						Year	Month	Day





4.1	a)	On what date did your patient first	consult you for this condition? Label Yea	r Month Day	
	b)	When did the insured first become	a patient of yours? Year Month	Day	
4.2		en did your patient first exhibit symperience impaired renal function?	otoms, suffer from kidney disease or	Year Month Day	
	Plea	ase provide details in that regard: _			
4.3	a)	Does your patient have end-stage in	rreversible failure of both kidneys?		
	b)	What caused the kidney failure?			
	c)	On what date did your patient begin	n dialysis?		
			Year Month Day		
		Has the patient had or going to hav	alysis on a regular basis? ☐ Yes ☐ No re a kidney transplant? ☐ Yes ☐ No		
4.4			aboratory investigations and examination		
4.4	1 100	ase provide the results of pertinent i	aboratory investigations and examination	ons.	
4.5	Plea	ase describe and provide dates for a etic predisposition:	ny of the patient's risk factors for kidney	y disease such as diabetes and	d hypertension, including
		,			
4.6	a)	Does the patient have a family history	ory of kidney disease? ☐ No ☐ Yes -	Please provide details in that r	regard:
				·	
	b)	Please provide information regarding	ng any other significant family history:		
4.7	Plea	ase provide the names and addresse	es of other physicians whom your patien	t consulted with regard to this	condition:
		Name of physician or hospital	Address	From (year - month - day)	To (year – month – day)





4. ATTENDING PHYSICIAN'S STATEMENT (cont.)

4.8	Please provide information on your patient's smoking habits, including the number of cigarettes smoke the patient smoked for the last time:	ed per day and the date on which							
4.9	Please provide any other information that would be helpful in assessing your patient's claim:								
Plea	ise provide copies of any specialist or hospital reports for use by our medical director.								
	contract requires that the diagnosis of a covered illness be made by a physician who is not a relative or a byou a relative or a business associate of the insured? \square Yes \square No	usiness	asso	ciate of	the insu	ıred.			
X		Date:		1 1					
Phys	ician's signature			Year	Month	Day			
Phys	ician's name	Licence	No.						

THE CLAIMANT IS RESPONSIBLE FOR ANY FEES CHARGED FOR THE COMPLETION OF THIS FORM.



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Claim

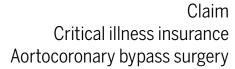
Critical illness insurance Aortocoronary bypass surgery

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	Group No. Employer No. Identification No.													
l.	INFORMATION ABOUT THE PARTICIPANT													
	Last name First name										Gen	der M 🗆	F	
	No. and street City													
	Province		Postal code			ŀ	Home te	I.						
2.	INFORMATION ABOUT THE CLAIMANT													
	Last name First name Gender □ M □ F										F			
	Date of birth													
	Address, if different from that of the participant													
	No. and street City													
	Province		Postal code			ŀ	Home te	i.				1		
	PLEASE NOTE THAT CLAIMANTS MUST HAVE THE ATTENDING PHYSICIAN'S S COMPLETED BY THEIR PHYSICIAN AND ARE RESPONSIBLE FOR ANY FEES CH			ON T	HE F	REVER	RSE SI	DE	OF	THIS	FORM			
3.	AUTHORIZATION													
	I authorize any physician, any other professional and any intervening party in the fie health and social services institution, any insurance company, as well as any reinsur that may receive such a mandate, any market intermediary, any employer or ex-emptiles or information, particularly medical records pertaining to myself, not including guardiale Civil Service Insurer Inc. or its mandataries, any information held that matter authorization is valid for the purposes of this contract and for any amendments considered as valid as the original. If you have applied for Family coverage status, the authorization of your spouse and	rer, a ploy gene ay b s, ex	any public ver, the pol etic test re pe required ktensions	or plicyh sult d for or re	orivat nolde s, and the p enew	e orga r as w d any o oroces als. A p	anizati ell as a of my o ssing o photoo	on, any dep of m	any pers end y file y of	infor son h ents, e. this a	mation olding _l to prov uthoriz	ager perso ide to	ncy nal	
								ı		- 1	1	1	1	
	Participant's signature or, if a minor, signature of legal guardian					[Date:		Ye	ar	Mont	h Da	Ll ay	
	X Spouse's signature					[Date:	L	⊥l Ye:		Mont	h Da		
								ı	16	aı	IVIOITE	1	ау	
	Dependent's signature if age 18 or over					[Date:		Ye	ar	Mont	h Da	ay	
	Dependent's signature if age 18 or over					[Date:	L	Ye	_ ar	Mont	h Da	ay	

IMPORTANT NOTE: When disclosing medical and health information, the results of any genetic test should not be included.





4.1	When did your patient first exhibit symptoms or suffer from cardiovascular disease? Year Month Day Please provide details in that regard:											
4.2	On what date did your patient first consult yo	ou for the symptoms experienced?	n Day									
	When did this person first become a patient of yours? Year Month Day Please provide the observations concerning the preoperative angiography or a copy of the report:											
4.5	Please provide a copy of the surgical report, if any, or provide information on the aortocoronary bypass surgery: Date of surgery:											
4.6	Please indicate the names and addresses of	the hospitals where the insured was treated and of the	physicians and surgeons consulted:									
	Name	Address	Period									
4.7	Please describe and provide dates for any o	f the patient's risk factors for cardiovascular disease, in	cluding genetic predisposition:									
4.8	Please include any other information cons	idered relevant and enclose copies of any specialist o	or hospital reports.									
X			Date:									
Phys	ician's signature		Year Month Day									
Phys	ician's name (please print)		Licence No.									



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Group No.

Claim

Critical illness insurance Multiple sclerosis

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1.	INFORMATION ABOUT THE PARTICIPANT												
	Last name	First name				Gender □ M □ F							
	No. and street		City										
	Province		'	Postal code		Home t	el.						
2.	INFORMATION ABOUT THE CLAIMANT												
	Last name	First name						Gende					
	Year Month Day Year Month Day	ent child											
	Address, if different from that of the participant No. and street												
	Province	Home t	el.										
	PLEASE NOTE THAT CLAIMANTS MUST HAVE THE ATTENDO COMPLETED BY THEIR PHYSICIAN AND ARE RESPONSIBLE				N THE REV	ERSE S	SIDE OF THIS	FORM					
3.	AUTHORIZATION												
	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 that may receive such a mandate, any market intermediary, any employer or ex-employer, the policyholder as well as any person holding persona files or information, particularly medical records pertaining to myself, not including genetic test results, and any of my dependents, to provide to La Capitale Civil Service Insurer Inc. or its mandataries, any information held 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 you have applied for Family coverage status, the authorization	n of your spouse a	and de	pendent ch	ildren age 1	8 or ove	er is also requi	red.					
	Participant's signature or, if a minor, signature of legal guardian					Date:	Year	Month	Day				
	X Chausala signatura					Date:	Vaar	Month	Day				
	Spouse's signature						Year	Month	Day				
	Dependent's signature if age 18 or over					Date:	 Year	Month	Day				
	X					Date:							
	Dependent's signature if age 18 or over						Year	Month	Day				

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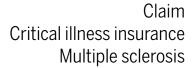
Identification No.

Employer No.



Claim Critical illness insurance Multiple sclerosis

4.1	a)	When did your patient first exhibit s What did they consist of?						
		On what date did your patient first of the whole when did the insured first become	consult you with regard to this condition	Year Month	Day			
4.2	Year Month Day Please provide an outline of the clinical course, and briefly describe the patient's neurological problems and symptoms, including the dates and durations of the flare-ups:							
4.3 On what date was the diagnosis of possible multiple sclerosis first discussed with the patient? Year Month Day								
4.4 Please provide:								
			e imaging report confirming the diagnosis and addresses of other physicians whom your patient consulted or hospitals where your patient received attention with s condition					
		Name of physician or hospital	Address	From (year – month – c	day)	To (year – month – day)		
	c) The name and address of the neurologist who confirmed the diagnosis							
	٠,	Neurologist's name	Address		Telep	phone No. including area code		
		J						
4.5	L.5 Does the patient have a family history of multiple sclerosis? ☐ No ☐ Yes − Please provide details in that regard:							
4.6	Does the patient have any other significant family history? ☐ No ☐ Yes −Please provide details in that regard:							





4. ATTENDING PHYSICIAN'S STATEMENT (cont.)

4.7	Please provide information on your patient's smoking habits, including the number of cigarettes smoked the patient smoked for the last time:	ed per day and the date on which			
4.8	Please provide any other information that would be helpful in assessing your patient's claim:				
Plea	se provide copies of any specialist or hospital reports for use by our medical director.				
	contract requires that the diagnosis of a covered illness be made by a physician who is not a relative or a byou a relative or a business associate of the insured? $\ \square$ Yes $\ \square$ No	ousiness associate of the insured.			
X		Date:			
Phys	ician's signature	Year Month Day			
Phys	ician's name (please print)	Licence No.			

THE CLAIMANT IS RESPONSIBLE FOR ANY FEES CHARGED FOR THE COMPLETION OF THIS FORM.