FOR OFFICE USE ONLY

Statement of Contributions
Group Insurance Plan

The original insurer must complete section **A** and affix its seal or stamp to this form.
The insurance certificate holder must complete sections **B** and **C**.

A - ORIGINAL INSURER

Identity of certificate holder

Last name at birth (in block letters) | Usual first name

Residential address
Number | Street | Apartment

Locality | Province | Postal code

Identity of original insurer | Period covered from (Year Month Day) to (Year Month Day) | Total contribution

B - INSURED PERSONS

Certificate holder and, where applicable, spouse

Health Insurance Number	First and Last Name	Date of birth (Year Month Day)	Sex (M or F)	Contributions attributed to this insured person

C - DECLARATION BY CERTIFICATE HOLDER OR BY HIS OR HER REPRESENTATIVE

I declare that the information provided is accurate, and I request that the amounts paid to my former insurer in the form of contributions be taken into account in calculating my maximum annual contribution to the Public Prescription Drug Insurance Plan.

SIGNATURE OF CERTIFICATE HOLDER

Date (Year Month Day) | Telephone number (home) Area code | Telephone number (work) Area code

Please send your duly signed form to the address below:

Régie de l'assurance maladie du Québec
P.O. Box 13000, Station Terminus
Service du centre de support aux pharmaciens, dépôt Q-006
Québec (Québec) G1K 9K1