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iA Financial Group

Underwritten by
Industrial Alliance Insurance & Financial Services Inc. (the "Company")
2165 Broadway W PO Box 5900, Vancouver, BC V6B 5H6

APPLICATION DEADLINE
March 31st, 2016

FOR OFFICE USE ONLY

APPLICATION FOR GUARANTEED ACCEPTANCE CRITICAL ILLNESS INSURANCE

Please complete, print and sign

POLICY INFORMATION

Name of Policyholder: Insurance Brokers Association of Ontario
Group Policy Number: 100010073
Division Number: 0001

MEMBER/EMPLOYEE INFORMATION MUST ALWAYS COMPLETE

Last Name | Given Name | Initials | Gender ❑ Male ❑ Female | Date of Birth (dd-mmm-yyyy)

Street Address | City | Prov. -- | Postal Code

Telephone (Home) | Telephone (❑ Work ❑ Cell) | Email

COVERAGE SELECTION CHECK ONLY ONE AMOUNT PER APPLICANT TYPE

❑ **Yes!** I would like to take this opportunity to apply for Guaranteed Acceptance Critical Illness Insurance without having to supply the medical evidence normally required.

MEMBER/EMPLOYEE

❑ $25,000 ❑ $50,000

Have you used any form of tobacco (except an average of one cigar a month), including nicotine products, electronic cigarettes, marijuana, hashish, smoking cessation products, betel nuts or leaves, supari, paan, gutka or shisha, within the last 12 months?

❑ **Yes** ❑ **No**

SPOUSE

❑ $25,000 ❑ $50,000

Have you used any form of tobacco (except an average of one cigar a month), including nicotine products, electronic cigarettes, marijuana, hashish, smoking cessation products, betel nuts or leaves, supari, paan, gutka or shisha, within the last 12 months?

❑ **Yes** ❑ **No**

DEPENDENT CHILD(REN)

❑ $5,000 ❑ $10,000

Amount selected will apply to each dependent children.

APPLICANT INFORMATION COMPLETE IF APPLYING FOR SPOUSE AND/OR DEPENDENT CHILDREN COVERAGE

SPOUSE

Last Name | Given Name | Initials | Gender ❑ Male ❑ Female | Date of Birth (dd-mmm-yyyy)

Are you also a member/employee of this group? ❑ Yes ❑ No If "Yes", please give details.

DEPENDENT CHILD(REN) IF YOU REQUIRE MORE SPACE, PLEASE ATTACH A SEPARATE SHEET OF PAPER, SIGNED AND DATED

Last Name	Given Name	Initials	Gender	Date of Birth (dd-mmm-yyyy)	Select one
			❑ Male ❑ Female		❑ Child ❑ Full-Time Post-Secondary Student
			❑ Male ❑ Female		❑ Child ❑ Full-Time Post-Secondary Student
			❑ Male ❑ Female		❑ Child ❑ Full-Time Post-Secondary Student
			❑ Male ❑ Female		❑ Child ❑ Full-Time Post-Secondary Student

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PAYMENT INFORMATION CHOOSE ONE

❑ **Monthly Pre-Authorized Debit (PAD)** — I have completed the Pre-Authorized Debit (PAD) Agreement Form (page 3), authorizing iA Financial Group to withdraw the required premium (plus applicable taxes) from my account.

❑ **Monthly Credit Card** — I authorize iA Financial Group to charge the required monthly premium (plus applicable taxes) to the credit card indicated below on or around the 1st business day of each month. I understand this amount may change at a future date as specified in the Master Group Policy. iA Financial Group will, to the best of its ability, advise me in writing of the revised amount in advance of its effective date. The monthly credit card option may be discontinued by me or iA Financial Group upon written notice.

❑ VISA
OR
❑ MasterCard

Cardholder Name | Credit Card Number | Expiry Date (mmm-yyyy)

AUTHORIZATION IMPORTANT INFORMATION ABOUT YOUR APPLICATION PLEASE READ CAREFULLY BEFORE SIGNING

This offer is only available to eligible members/employees, their spouses and their dependent children. Applications must be post-marked on or before the deadline date noted above which cannot be extended.

1. I understand that no benefit will be payable if an insured is diagnosed with a Covered Condition or AdvanceCare Benefit Condition within the first 24 months immediately following the effective date of coverage which results directly or indirectly from a Pre-Existing Condition. "Pre-Existing Condition" means illness, disease, mental, nervous or psychiatric condition or disorder for which any one of medical advice, treatment, service, prescribed medication, diagnosis or consultation, including consultation to investigate, and/or diagnose (where diagnosis has not yet been made) was received by the insured or would have been received by a prudent individual within the 24 months immediately preceding the effective date of coverage.
2. I understand that coverage will be void and all premiums refunded if, within the first 90 days of coverage, an insured is diagnosed with Benign Brain Tumour, Cancer (Life-Threatening) or Early Stage Cancer or have any signs, symptoms or investigations that lead to a diagnosis of Benign Brain Tumour, Cancer (Life-Threatening) or Early Stage Cancer, regardless of when the diagnosis is actually made.
3. I confirm I have not made any misrepresentations regarding age, gender, smoking status or eligibility and understand that if I have done so, coverage will be void.
4. I acknowledge that I have read the Notice on Privacy and Confidentiality (attached) summarizing certain privacy practices regarding collection, use and disclosure of my personal information.
5. I agree to the use of my personal information for the purposes outlined in this application. I understand that my consent to the use of any information to offer me products and services is optional, and that if I wish to discontinue such use I may call or write to Industrial Alliance Insurance and Financial Services Inc. (the "Company") at the telephone number or address shown on this application.
6. I understand that coverage will take effect on the date this completed application is received by the Company and my first month's premium has been paid.

X _____ Date (dd-mmm-yyyy)

Member/Employee Signature
(must always sign)

X _____ Date (dd-mmm-yyyy)

Spouse Signature
(if applying)

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PRE-AUTHORIZED DEBIT (PAD) AGREEMENT

STEP 1 - PROVIDE DETAILS FOR MONTHLY PRE-AUTHORIZED DEBITS

ATTACH A PERSONALIZED 'VOID' CHEQUE OR COMPLETE THE INFORMATION BELOW

ACCOUNT DETAILS

Name(s) of Account Holder(s) as shown on Financial Institution records

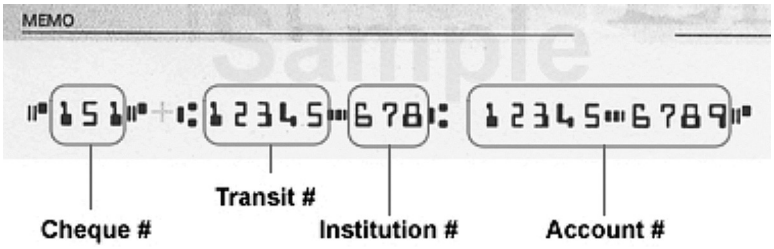
Street Address of Account Holder(s) | City | Prov. | Postal Code

Name of Financial Institution

Street Address of Branch | City | Prov. | Postal Code

Financial Institution Number | Transit Number | Account Number

ACCOUNT DETAILS (see sample below)



STEP 2 - REVIEW AND PROVIDE AUTHORIZATION

WITHDRAWAL ARRANGEMENT

❑ Fixed ☑ Variable

RECOURSE

You have certain recourse rights if any debit does not comply with this agreement. For example, you have the right to receive reimbursement for any debit that is not authorized or is not consistent with this PAD Agreement. To obtain more information on your recourse rights, contact your financial institution or visit www.cdnpay.ca.

AUTHORIZATION FORM MUST BE SIGNED IN INK

I/we, as the Account Holder(s), authorize Industrial Alliance Insurance and Financial Services Inc. (the "Company") and the financial institution named above or as indicated on the attached 'VOID' cheque, to withdraw variable monthly payments from my/our account, at the branch indicated, for the purpose of collecting premiums and any applicable sales tax and service charges for insurance under this policy.

The PAD amount will be debited from the account indicated above on the 1st day of each month or the next business day. I/we agree to notify the Company in writing, if there is any change to the banking information set out above.

I/we waive the right to receive pre-notification of the amount to be debited each month and the date of such debit. I/we agree that the Company will provide written notice of the amount of the PAD at least three (3) calendar days before the first PAD is debited and before any increase to the PAD amount is debited, except when the increase is due to a change in sales taxes, service charges, or the increase to the PAD amount is a result of my/our request.

I/we may cancel this PAD Agreement at any time, subject to providing notice to the Company at the address provided below. This notification must be received at least ten (10) business days before the next debit is scheduled. I/we may obtain a sample cancellation form, or more information on my/our right to cancel a PAD Agreement at my/our financial institution or by visiting www.cdnpay.ca.

I/we understand that cancellation of this PAD Agreement will not have any effect on the insurance provided under this policy, provided that payment is received when due and is made in accordance with the terms of this policy.

This PAD Agreement only applies to the method of payment. I/we understand that completing this PAD Agreement does not mean that the application for insurance coverage has been approved.

X

Member/Employee Signature
(must always sign)

Date (dd-mmm-yyyy)

X

Signature of all other Account Holder(s)
(if a required signatory to this account)

Date (dd-mmm-yyyy)

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NOTICE ON PRIVACY & CONFIDENTIALITY PLEASE READ CAREFULLY AND RETAIN FOR YOUR RECORDS

The specific and detailed information requested pursuant to this application from you and which may be subsequently requested by us, from time to time, is required to process your application, and process any claim for benefits made by you. To protect the confidentiality of such personal information, access to your information is restricted to any person you authorize or as authorized by law as well as those Industrial Alliance Insurance and Financial Services Inc. (the "Company") employees, its reinsurers, third party administrators, agents or brokers of the Company, plan sponsors and any agents or brokers of such sponsors or other market intermediaries for the purposes of (a) sponsoring a plan for you, (b) marketing and administration of Company products or services, (c) assessment of risk (underwriting) and (d) investigation of claims (where applicable). **Your file will be kept in our offices.**

You are entitled to review your personal information contained in our files, subject to certain limited exceptions established by law, and if necessary, to have it rectified by sending a written request to us at: 2165 West Broadway. P.O. Box 5900, Vancouver, BC V6B 5H6, Attention: Director, Administration, Special Markets Solutions. Corrections will be noted in the file. If a requested correction is in dispute, we nonetheless note your requested correction in the file. Further information on our privacy practices can be found online at **ia.ca** or alternatively, contact us at 1.800.266.5667 and request that a copy be faxed or mailed to you.

SEND YOUR COMPLETED FORM TO:

SPECIAL MARKETS solutions

Special Markets Solutions
Industrial Alliance Insurance and Financial Services Inc.
2165 Broadway W, PO Box 5900, Vancouver, BC V6B 5H6
Or fax to 1.888.553.5433 (toll free)

QUESTIONS?

Contact a Client Service Specialist at:
1.800.266.5667 (toll free)
604.737.3802 (Vancouver)
solutions@ia.ca
Monday to Friday 6:30 a.m. - 4:30 p.m. Pacific Time