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iA Financial Group

Underwritten by:
Industrial Alliance Insurance & Financial Services Inc.
400–988 Broadway W PO Box 5900, Vancouver, BC V6B 5H6

FOR OFFICE USE ONLY

APPLICATION FOR EXTENDED HEALTH & DENTAL INSURANCE

Please complete, print and sign.

POLICY INFORMATION

Name of Policyholder/Association: MOUNT ROYAL UNIVERSITY ALUMNI ASSOCIATION

Group Policy Number: 100006269

MEMBER INFORMATION

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

Gender: ○ Male ○ Female

Place of Birth

Street Address | City | Prov. | Postal Code

Prov.: --

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

INSURANCE PLAN SELECTION WHICH TYPE OF INSURANCE PLAN DO YOU NEED?

- ○ Extended Health & Dental (Standard)
- ○ Extended Health & Dental (Enhanced)
- ○ Extended Health & Prescription Drugs (Standard)
- ○ Extended Health & Prescription Drugs (Enhanced)
- ○ Extended Health, Dental & Prescription Drugs (Standard)
- ○ Extended Health, Dental & Prescription Drugs (Enhanced)

INDIVIDUALS TO BE COVERED

Eligibility: The member must apply in order for the spouse and dependent children to be eligible for coverage. All persons to be insured must be residing in Canada and be enrolled in a Provincial Health Plan. Members and spouses must be less than 61 years of age and dependent children less than 25 years of age at the time of application. Residents of Quebec must have basic prescription drug coverage by RAMQ, their employer or otherwise.

	Full Name of Person to be Insured	Health Card Number	Gender	Date of Birth (dd-mmm-yyyy)	**Smoker?** If "Yes" please include # of cigarettes smoked daily	Height	Weight
Member			○ Male ○ Female		○ Yes ○ No	○ ft/in ○ cm	○ lbs ○ kgs
Spouse			○ Male ○ Female		○ Yes ○ No	○ ft/in ○ cm	○ lbs ○ kgs
Child			○ Male ○ Female		○ Yes ○ No	○ ft/in ○ cm	○ lbs ○ kgs
Child			○ Male ○ Female		○ Yes ○ No	○ ft/in ○ cm	○ lbs ○ kgs
Child			○ Male ○ Female		○ Yes ○ No	○ ft/in ○ cm	○ lbs ○ kgs

If you have more than 3 dependent children, please attach a separate sheet with all applicable information.

GENERAL INFORMATION

Are you and/or your spouse now covered or did you have previous health insurance coverage with Industrial Alliance Insurance and Financial Services Inc. or any other insurance company? ○ Yes ○ No

If "Yes", please indicate:

	Plan Number	ID Number	Insurance Company	Date Benefits Ended (dd-mmm-yyyy)
Member				
	Plan Number	ID Number	Insurance Company	Date Benefits Ended (dd-mmm-yyyy)
Spouse				

Is this application intended to replace your current coverage? ○ Yes ○ No

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PERSONAL PHYSICIAN INFORMATION MUST ALWAYS BE COMPLETED WHEN APPLYING

Member's Personal Physician Information

Personal Physician's Name | Telephone

Street Address | City | Prov. | Postal Code

Date last consulted ANY Doctor (dd-mmm-yyyy) | Reason for consultation

Results (e.g. normal), diagnosis, treatment or medication prescribed

Spouse's Personal Physician Information

Personal Physician's Name | Telephone

Street Address | City | Prov. | Postal Code

Date last consulted ANY Doctor (dd-mmm-yyyy) | Reason for consultation

Results (e.g. normal), diagnosis, treatment or medication prescribed

Dependent Child's Personal Physician Information

Child's Name

Personal Physician's Name | Date last consulted ANY Doctor (dd-mmm-yyyy)

Reason for consultation | Results (e.g. normal), diagnosis, treatment or medication prescribed

Child's Name

Personal Physician's Name | Date last consulted ANY Doctor (dd-mmm-yyyy)

Reason for consultation | Results (e.g. normal), diagnosis, treatment or medication prescribed

Child's Name

Personal Physician's Name | Date last consulted ANY Doctor (dd-mmm-yyyy)

Reason for consultation | Results (e.g. normal), diagnosis, treatment or medication prescribed

Have any of the applicants experienced a weight change of more than 10 lbs. during the last 12 months? ○ Yes ○ No

If "Yes", please answer the following:

First Name	What was the amount of the weight change?	Was this a gain or a loss?	Reason
	○ lbs ○ kgs	○ Gain ○ Loss	
First Name	What was the amount of the weight change?	Was this a gain or a loss?	Reason
	○ lbs ○ kgs	○ Gain ○ Loss	

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HEALTH & LIFESTYLE QUESTIONS

If you answer "Yes" to any of the following questions, please provide details in the Additional Details section below.			Yes	No
1)	**Have you, your spouse or any listed dependent child ever consulted a Physician about, been treated for, or had any known indication of:**		☐	☐
	a)	High blood pressure, stroke, transient ischemic attack (TIA), chest pain, angina, high cholesterol or other heart or circulatory disorders, dizziness, fainting or blood disorder?	☐	☐
	b)	Back, joint or any musculoskeletal pain or disorder, arthritis or rheumatism?	☐	☐
	c)	Digestive system disorder, liver disease or disorder including hepatitis?	☐	☐
	d)	Depression, stress, mental, emotional or nervous disorder?	☐	☐
	e)	Alcohol or drug abuse?	☐	☐
	f)	Asthma, allergy, respiratory disorder, or shortness of breath?	☐	☐
	g)	Immune disorder including testing for Acquired Immune Deficiency Syndrome (AIDS), Human Immunodeficiency Syndrome (HIV)?	☐	☐
	h)	Cancer, tumour or any growth?	☐	☐
	i)	Skin disorder?	☐	☐
	j)	Infertility, reproductive disorder or menopause?	☐	☐
	k)	Bladder, kidney or other genitourinary disorder?	☐	☐
	l)	Headaches, migraines, eye or ear disorder?	☐	☐
	m)	Diabetes or other endocrine disorder?	☐	☐
	n)	Other condition, disease or disorder not mentioned above?	☐	☐
2)	Have you, your spouse or any listed dependent child ever been treated for, hospitalized or had any physical impairment, congenital abnormality, medical condition, disease or disorder not stated above?		☐	☐
3)	Have you, your spouse or any listed dependent child ever been advised to have an investigation, hospitalization or surgery which has never been completed?		☐	☐
4)	Have you, your spouse or any listed dependent child been disabled and/or unable to perform normal daily activities from any cause for at least 2 consecutive weeks within the last 5 years?		☐	☐
5)	Are you, your spouse or any listed dependent child pregnant?		☐	☐

ADDITIONAL DETAILS

If you answer "Yes" to any questions above, please provide details below

Question Number	Name of person to be insured	Details (include dates, duration and names and addresses of all doctors, hospitals, etc.). If you require more space, please attach a separate sheet of paper, signed and dated.

ADDITIONAL MEDICAL INFORMATION

List all medications or other treatment (therapy, counselling, etc.) that any individual to be insured is currently taking, or expects to be taking, or that has been prescribed within the past 12 months, including unfilled prescriptions. If you need more space, please use a separate sheet of paper, signed and dated.

Note: Please do not include medications used to treat minor ailments like cold or flu.

Name of Person to be Insured	Medication or Treatment	Date Prescribed (dd-mmm-yyyy)	Dosage and Frequency	Monthly Cost	Date Discontinued and Duration (If Applicable)	Reason for Use

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PAYMENT INFORMATION PLEASE CHOOSE YOUR PAYMENT OPTION BELOW

☐ **Monthly Pre-Authorized Debit (PAD)**
I have completed the attached Pre-Authorized Debit (PAD) Agreement form authorizing Industrial Alliance Insurance and Financial Services Inc. (the "Company") to withdraw the required premium (plus applicable taxes) from my account.

☐ **Cheque**
I have attached a cheque for the first month's premium payable to "iA Financial Group". I understand the balance of the premium (plus applicable taxes) will be billed once my coverage is approved.

☐ **For existing clients only**
Use my current payment method.

☐ **Bill me**
Send me a Premium Statement once my coverage has been approved. I understand coverage will not take effect until my first month's premium has been received.

AUTHORIZATION FORM MUST BE SIGNED IN INK

I acknowledge receipt of the Disclosure Notice (attached) describing the operation of the Medical Information Bureau. I authorize:

a) any health care professional as well as any other public or private health or social service establishment, any insurance company, the Medical Information Bureau, any insurance plan sponsor, any agent, broker or market intermediary, any third party administrator, any personal information agents or professional investigation agencies and any government agency, or other organization, institution or person that has any records or knowledge of me or my health, to give to Industrial Alliance Insurance and Financial Services Inc. (the "Company") or its reinsurers any such information for the purpose of the risk assessment, administration or investigation of a subsequent claim.

b) the Company or its reinsurers to release and exchange any personal information obtained to the above persons and organizations for the purposes of assessment of this application, the administration of any certificate issued and the investigation of any claim.

c) the Company to test and evaluate a specimen of my blood, urine or saliva for the purpose of assessing me as an insurance risk. This analysis includes testing for HIV infection.

d) the Company to release any abnormal test results to my personal physician.

I acknowledge that all correspondence relating to this application, including the requirement for additional medical information and the communication of any underwriting decision, will be directed to the applicant. In the case of a dependent child, it will be directed to the member.

I further acknowledge receipt of the Notice on Privacy and Confidentiality (attached) summarizing certain privacy practices regarding collection, use and disclosure of my personal information.

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 the Company at the telephone number or address shown on this application.

I confirm that the foregoing answers, forming part of an application for group insurance to the Company are true, full, complete and correctly recorded, and together with any other forms signed by me in connection with this application form the basis for any certificate issued hereunder. I understand that any group insurance arising from this application may not be valid if there is any incorrect answer or misrepresentation in this application or if there is any change in my insurability between the date of this application and the effective date of coverage. I acknowledge that it is my responsibility to notify the Company of any change in my health or insurability. I agree that my insurance will not take effect until my properly completed application has been approved by the Company and the first month's premium has been paid.

A copy of this signed authorization shall be as valid as the original.

X _____ Date (dd-mmm-yyyy) _____

Member Signature
(must always sign)

X _____ Date (dd-mmm-yyyy) _____

Spouse Signature
(if applying)

X _____ Date (dd-mmm-yyyy) _____

Dependent Signature
(if 16 or older)

X _____ Date (dd-mmm-yyyy) _____

Dependent Signature
(if 16 or older)

X _____ Date (dd-mmm-yyyy) _____

Dependent Signature
(if 16 or older)

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PRE-AUTHORIZED DEBIT (PAD) AGREEMENT

Please complete, print and sign.

POLICY INFORMATION

Name of Policyholder

Group Policy Number

MEMBER/EMPLOYEE INFORMATION

Last Name | Given Name | Initials

CHEQUE/ACCOUNT DETAILS FOR MONTHLY PRE-AUTHORIZED DEBITS

PLEASE ATTACH A PERSONALIZED 'VOID' CHEQUE OR COMPLETE THE INFORMATION BELOW.
IF YOU DON'T HAVE A CHEQUE, YOU CAN REQUEST A DIRECT DEPOSIT FORM FROM YOUR FINANCIAL INSTITUTION.

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

PAD CATEGORY

IF THIS IS NOT FILLED IN,
THE PAD WILL BE TREATED AS PERSONAL

○ Personal Expense ○ Business Expense

Withdrawal Arrangement

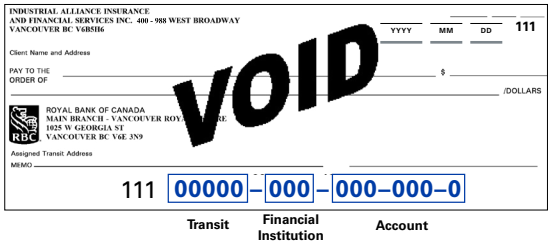
○ Fixed ✓ Variable

Transit Number (See sample ➔)

Financial Institution Number (See sample ➔)

Account Number (See sample ➔)

Sample ➥



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.payments.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 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. However, the Company will provide written notice of the amount of the first PAD at least three (3) calendar days before the first PAD is debited.

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.payments.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)

FORM 4425 PDF (AUG/2018)

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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: 400–988 West Broadway. P.O. Box 5900, Vancouver, BC V6B 5H6, Attention: Director, 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.

DISCLOSURE NOTICE - MEDICAL INFORMATION BUREAU PLEASE READ CAREFULLY AND RETAIN FOR YOUR RECORDS

Information regarding your insurability will be treated as confidential. Industrial Alliance Insurance and Financial Services Inc. (the "Company") and its reinsurers may, however, make a brief report thereon to the Medical Information Bureau (MIB), a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such company, MIB, upon request, will supply that company with the information it may have in its files.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction. The address of MIB's Information office is: Medical Information Bureau, 330 University Avenue, Toronto, Ontario, Canada M5G 1R7, telephone number (416) 597-0590.

The Company may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

SEND YOUR COMPLETED FORM TO

SPECIAL MARKETS SOLUTIONS

Special Markets Solutions
Industrial Alliance Insurance and Financial Services Inc.
400–988 Broadway W, PO Box 5900, Vancouver, BC V6B 5H6

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

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