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iA Financial Group

GROUP POLICY NO. **100007862**

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 VOLUNTARY CRITICAL ILLNESS INSURANCE

Please complete, print and sign.

EMPLOYEE INFORMATION MUST ALWAYS BE COMPLETED

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

Place of Birth | Occupation

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

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

SPOUSE INFORMATION COMPLETE THIS SECTION WHEN APPLYING FOR SPOUSAL COVERAGE

Are you also a CISVA employee? ○ **Yes** ○ **No** If "Yes", please complete a separate application.
What is your spousal status: ○ Married ○ Civil Union ○ Common-Law, please provide date of cohabitation (dd-mmm-yyyy)

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

Place of Birth | Occupation

INSURANCE INFORMATION SELECT INSURANCE APPLYING FOR

○ **Employee Critical Illness Insurance** (Units of $25,000 to $300,000 max.)
Total amount of insurance requested (include any existing amounts)

○ **Spouse Critical Illness Insurance** (Units of $25,000 to $300,000 max.)
Total amount of insurance requested (include any existing amounts)

○ **Dependent Children Critical Illness Insurance***
(Units of $5,000 to $10,000 max. – Available only if the member is insured or applying for Critical Illness Insurance)
Total amount of insurance requested (include any existing amounts)

***If applying for Dependent Children Critical Illness Insurance, please complete a Supplemental Dependent Questionnaire # 4584**

FAMILY HISTORY QUESTION MUST ALWAYS BE COMPLETED WHEN APPLYING

Have any of your natural parents, brothers or sisters ever undergone bypass surgery or suffered from any of the following conditions: Heart attack, angina or any other heart condition, stroke, polycystic kidney disease, diabetes, cancer (if "Yes", specify type), Alzheimer's disease, Parkinson's disease, multiple sclerosis, amyotrophic lateral sclerosis (ALS), Huntington's disease, alcoholism, nervous or mental disorder, or any other hereditary disease?

Employee		Spouse	
Yes ○	**No** ○	**Yes** ○	**No** ○

If "Yes", please complete the following table. If you require more space, please attach a separate sheet of paper, signed and dated.

	Employee			Spouse		
	Condition	Age at Onset/ Diagnosis	Age at Death (if applicable)	Condition	Age at Onset/ Diagnosis	Age at Death (if applicable)
Father						
Mother						
Brothers						
Sisters						

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HEALTH AND LIFESTYLE QUESTIONS MUST ALWAYS BE COMPLETED WHEN APPLYING

If you answer "Yes" to any question below (or "No" to question 8), please complete the Additional Details section below.		Employee		Spouse	
		Yes	No	Yes	No
1)	**Employee:** **Height:** ◯ ft/in ◯ cm **Weight:** ◯ lbs ◯ kgs				
2)	**Spouse:** **Height:** ◯ ft/in ◯ cm **Weight:** ◯ lbs ◯ kgs				
3)	Have you used any form of tobacco (except an average of one cigar a month), including nicotine products, electronic cigarettes, marijuana mixed with tobacco, hashish mixed with tobacco, smoking cessation products, betel nuts or leaves, supari, paan, gutka or shisha, within the last 12 months? If "Yes", indicate product used and provide details below.	◯	◯	◯	◯
4)	Have you flown as a pilot, student or crew member in the last two years or do you have any intention to do so?	◯	◯	◯	◯
5)	Have you engaged in or do you intend to participate in scuba diving, parachuting or other hazardous sport or activity?	◯	◯	◯	◯
6)	Do you intend to travel or reside outside Canada or the United States for more than a month?	◯	◯	◯	◯
7)	Have you had a request for life, disability or critical illness insurance declined, postponed, rated or modified in any way?	◯	◯	◯	◯
8)	Are you now actively engaged in your occupation on a full-time basis? If "No", please provide details including reason why you are not working on a full-time basis.	◯	◯	◯	◯
9)	Have you ever had or ever been treated for cancer, tumour, cyst, polyp or other growth, moles, anemia, blood disorder or any form of malignant disease? Any immune system abnormality including AIDS (Acquired Immune Deficiency Syndrome), positive HIV test, enlargement of lymph glands, unusual skin lesions, or unexplained infections?	◯	◯	◯	◯
10)	Have you ever had or have you ever been treated for chest pain, angina, heart attack, high blood pressure, abnormal ECG, stroke, paralysis, transient ischemic attack (TIA), elevated cholesterol, or other disorders of the heart or aorta, blood vessels or circulatory system? Diabetes, pancreatitis, thyroid or other endocrine disorder? Lung or other respiratory disease or disorder? Any disorder of the eyes (excluding near or far sightedness), ears, vocal chords or larynx including loss of speech?	◯	◯	◯	◯
11)	Have you ever been treated for or diagnosed with kidney, bladder, prostate (including an elevated PSA test result) or breast disorder (including cysts, lumps, biopsy or abnormal mammogram or ultrasound) or other genitourinary disorder, hepatitis B or C (including carrier), cirrhosis or other liver disorder, ulcerative colitis, Crohn's disease or other disorder of the gastrointestinal tract?	◯	◯	◯	◯
12)	Have you ever had or have you ever been treated for dizziness, seizures, epilepsy, tremor, paresthesia, loss of balance, numbness, multiple sclerosis, Alzheimer's disease, Parkinson's disease, amyotrophic lateral sclerosis (ALS) or any other neurological disorder? Stress, anxiety, depression or any other psychiatric disorder? Disease or disorder of muscles, ligaments, tendons, bones or joints including but not limited to arthritis, lupus in any form, amputation or deformity?	◯	◯	◯	◯
13)	Have you ever used marijuana, heroin, morphine, cocaine, LSD, barbiturates, amphetamines, or any other drug or narcotic, except as prescribed by your physician?	◯	◯	◯	◯
14)	a) Do you presently drink more than 12 alcoholic beverages per week? If "Yes", state number, kind and frequency consumed.	◯	◯	◯	◯
	b) Have you ever changed your pattern of drinking (increased or decreased), received advice or treatment for, or attended any rehabilitation program for alcohol or drug use?	◯	◯	◯	◯
15)	Have you any condition for which hospitalization, further testing, investigation or surgery has been advised, or which have not yet been done, or for which you are still awaiting results?	◯	◯	◯	◯
16)	Are you taking any prescribed medication? If "Yes", state name of medication and reason for use.	◯	◯	◯	◯
17)	Are you aware of any symptoms or complaints regarding your health for which you have not yet consulted a physician or received treatment?	◯	◯	◯	◯
18)	Have you been absent from work for more than seven consecutive days within the past year due to sickness or injury?	◯	◯	◯	◯
19)	Has there been a variation in your weight in the past year? If "Yes", please provide details including reason and number of pounds/kilograms gained or lost.	◯	◯	◯	◯
20)	Females only: Are you currently pregnant? If "Yes", please provide your estimated due date and advise of any complications with current or past pregnancies.	◯	◯	◯	◯
21)	During the past 10 years, have you consulted a physician, received treatment or been hospitalized, had surgery or any test **(other than routine checkup or minor injury)** for any disease, disorder or ailment not already mentioned?	◯	◯	◯	◯
22)	Have you ever received or claimed benefits or a pension for sickness, injury or impairment?	◯	◯	◯	◯
23)	Do you have any pending criminal offences, criminal convictions, had your driver's license suspended, or within the past 3 years been convicted of more than 3 traffic violations?	◯	◯	◯	◯

ADDITIONAL DETAILS IF ANY OF QUESTIONS 3-23 ARE ANSWERED "YES" (OR "NO" TO QUESTION 8), 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.

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PERSONAL PHYSICIAN INFORMATION MUST ALWAYS BE COMPLETED WHEN APPLYING

Employee'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

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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.

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.

I wish to participate in this insurance plan and, if my application is approved, I authorize the deduction of the appropriate premium from my salary.

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

X		X	
Employee Signature (must always sign)	Date (dd-mmm-yyyy)	**Spouse Signature** (if applying)	Date (dd-mmm-yyyy)

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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

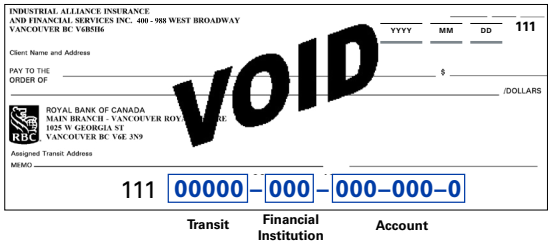
○ Fixed ✓ Variable

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