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FINANCIÈRE SISIP FINANCIAL
A division of CFMWS
Une division des SBMFC

iA Financial Group

REQUEST FOR NON-SMOKER RATES

To be eligible for non-smoker rates, you must not have 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 and must provide satisfactory evidence of insurability.

Please complete, print and sign

POLICY INFORMATION

Group Policy Number: 100011627

iA Reference Number:

MEMBER INFORMATION MUST ALWAYS BE COMPLETED

Last Name | Given Name | Initials | Service Number

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

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

SPOUSE INFORMATION COMPLETE THIS SECTION WHEN SPOUSE IS APPLYING FOR NON-SMOKER RATES

Last Name | Given Name | Initials

PERSONAL PHYSICIAN INFORMATION

Member's Personal Physician or Clinic

Personal Physician's Name/Clinic 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 or Clinic

Personal Physician's Name/Clinic 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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HEALTH AND LIFESTYLE QUESTIONS MUST ALWAYS BE COMPLETED WHEN APPLYING

		Member		Spouse	
		Yes	No	Yes	No
1)	**Member:** **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 **ever** used any of the items listed in Question 3? If "Yes", please indicate which products were used and when usage stopped in the Additional Details section below.	○	○	○	○
5)	What is your present occupation? Give details of any proposed changes in the Additional Details section below.				
6)	Since your insurance coverage was issued:				
	a) 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?	○	○	○	○
	b) 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?	○	○	○	○
	c) 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?	○	○	○	○
	d) 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?	○	○	○	○
	e) Have you any condition for which hospitalization, further testing, investigation or surgery has been advised, or which have not yet been done?	○	○	○	○
	f) Do you have any reason to believe you are suffering from any disorder, or are you taking any prescribed medication?	○	○	○	○
	g) Have you consulted a physician or received treatment for any disease, disorder, ailment or injury not already mentioned?	○	○	○	○
	h) Have you ever had a request for life, critical illness or health insurance declined, postponed, rated, or restricted in any way? If "Yes", please provide reason.	○	○	○	○
	Outside of your military duties as an a Serving Member:				
7)	Have you flown as a pilot, student or crew member in the last two years or do you have any intention to do so? If "Yes", indicate dates and other details below.	○	○	○	○
8)	Have you engaged in or do you intend to participate in scuba diving, parachuting or other hazardous sport or activity? If "Yes", indicate type of sport/ activity, dates and other details below.	○	○	○	○
9)	Do you intend to travel or reside outside Canada or the United States for more than a month? If "Yes", specify the place, period, dates and reason.	○	○	○	○

ADDITIONAL DETAILS IF YOU ANSWER "YES" TO ANY QUESTION, PROVIDE DETAILS BELOW

Question Number	Name of person to be insured	Details If you require more space, please attach a separate sheet of paper, signed and dated.

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DECLARATION AND 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. 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		X	
Member Signature (must always sign)	Date (dd-mmm-yyyy)	**Spouse Signature** (if applying)	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, 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.
2165 Broadway W, PO Box 5900, Vancouver, BC V6B 5H6

QUESTIONS?

Contact a Client Service Specialist at:
1.855.747.4717 (toll-free)
sisipci@ia.ca
Monday to Friday 6:30 a.m. - 4:30 p.m. Pacific Time