

TERMINATION REQUEST FORM

Specified coverage will terminate as per the terms of the group policy.

POLICY INFORMATION

Group Policy Number	iA Reference Number
100011627	

MEMBER INFORMATION

Last Name	Given Name	Initials	Service Number

YOUR CURRENT MAILING ADDRESS REQUIRED FOR TERMINATION CONFIRMATION AND REFUND OF PREMIUMS, IF APPLICABLE

Street Address	City	Prov.	Postal Code
Telephone (Home)	Telephone (<input type="radio"/> Work <input type="radio"/> Cell)	Email	

TERMINATION SPECIFICATIONS

Option 1	<input type="radio"/> Terminate all coverage under the above-mentioned group policy												
Option 2	<p>If you do not wish to terminate all coverage under the group policy, select below which benefit(s) you would like terminated:</p> <table border="1"> <tr> <td>Member</td> <td>Spouse</td> <td>Dependent Children*</td> </tr> <tr> <td><input type="radio"/> All Member benefits</td> <td><input type="radio"/> All Spouse benefits</td> <td><input type="radio"/> All dependent benefits</td> </tr> <tr> <td></td> <td></td> <td><input type="radio"/> Other (please specify)</td> </tr> <tr> <td></td> <td></td> <td></td> </tr> </table>	Member	Spouse	Dependent Children*	<input type="radio"/> All Member benefits	<input type="radio"/> All Spouse benefits	<input type="radio"/> All dependent benefits			<input type="radio"/> Other (please specify)			
Member	Spouse	Dependent Children*											
<input type="radio"/> All Member benefits	<input type="radio"/> All Spouse benefits	<input type="radio"/> All dependent benefits											
		<input type="radio"/> Other (please specify)											

* Note if you are terminating the dependent coverage for only some of your dependent children, please specify their names listed on a separate piece of paper attached to this form, otherwise the termination will apply to all dependent children covered under the benefit.

Please provide the reason for terminating your coverage.

Reasons for Termination: Spouse is no longer eligible for coverage as of _____ (dd-mmm-yyyy)
 Service needs improvement No Longer need coverage Product does not meet my needs Cost Other

Tell us more: _____

AUTHORIZATION FORM MUST BE SIGNED IN INK

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

<p>X</p> <p>_____ Member Signature (must always sign)</p>	<p>X</p> <p>_____ Spouse Signature (if applicable)</p>
Date (dd-mmm-yyyy)	Date (dd-mmm-yyyy)

SEND YOUR COMPLETED FORM TO



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