

Underwritten by: Industrial Alliance Insurance & Financial Services Inc. 2165 Broadway W PO Box 5900, Vancouver, BC V6B 5H6

APPLICATION DEADLINE

March 31, 2017

FOR OFFICE USE ONI	LY	

APPLICATION FOR GUARANTEED ACCEPTANCE GROUP CRITICAL ILLNESS INSURANCE

Please complete, print and sign

POLICY INFORMA	TION									
Name of Policyholder				Gı	roup Policy I	Division Number				
ALPA Canada Insur	ance Trust			1	00007	365				
		\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\								
	TATION MUST ALWA									
Last Name		iiven Name			Initials	Gender □ Male □ Female		Birth (dd-mmm-yyyy)		
ALPA Member ID										
Street Address			City				Prov.	Postal Code		
Telephone (Home)	Telep	ohone (네)	Email						
COVERAGE SELEC	CTION CHECK ONLY	ONE PER APP	LICANT TYI	PE						
	like to take this opportunity t t having to supply the medica			Critical Illness In	nsurance					
MEMBER		SPOUSE			DE	PENDE	NT CHILI	D(REN)		
□ \$25,000 □	\$50,000	\$25,000	3 \$50	,000		\$5,000) 🗖 \$	10,000		
Have you used any form of to of one cigar a month), include electronic cigarettes, marijua cessation products, betel nurgutka or shisha, within the la	ling nicotine products, ana, hashish, smoking ts or leaves, supari, paan,	Have you used any of one cigar a month electronic cigarettes cessation products, gutka or shisha, with	h), including nicc s, marijuana, hasl betel nuts or lea nin the last 12 m	ntine products, hish, smoking oves, supari, paan	chil	ount selected dren.	d will apply t	o each dependent		
ADDITION INFOR	RMATION COMPLET	E IE APPI VING	EOR SPOL	ISE AND/OF	DEDEN	JDENT CE	JII DRENI	COVERAGE		
SPOUSE	AMATION COM LLT	LII AITLIING	101(3) 00	ISL AND/OF	(DLI LI	NDLINI CI	IILDINLIN	COVERAGE		
Last Name		Given Name			Initials	Gender □ Male □ Female		Birth (dd-mmm-yyyy)		
Are you also a member of this	group? ☐ Yes ☐ No If "Yes",	provide ALPA Member	ID			■ r emale				
DEPENDENT CHILD(R	EN) IF YOU REQUIRE MOI	RE SPACE, PLEASE	E ATTACH A SE	EPARATE SHE	ET OF PAI	PER, SIGNE	D AND DAT	-ED		
Last Name	Given Name	Initials	Gender	Date of Birth (d	ld-mmm-yyy	y) Select o	one			
			☐ Male ☐ Female			☐ Chile	d 🖵 Full-Tin	ne Post-Secondary Studen		
Last Name	Given Name	 Initials	Gender	Date of Birth (d	ld-mmm-yyy	ry) Select (one			
			☐ Male			☐ Chile	d 🗖 Full-Tin	ne Post-Secondary Studen		
Last Name Given Name		Lnitials	☐ Female Gender	Date of Birth (d	ld-mmm-vvv			,		
			■ Male		, , , ,	•		☐ Full-Time Post-Secondary Stude		
Last Name	Given Name	 Initials	☐ Female Gender	Date of Birth (d	ld-mmm-vvv			in a second second		
			☐ Male ☐ Female			•		ne Post-Secondary Studen		



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Member Signature (must always sign)

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PAYMENT	INFORMATION	N CHOOSE ONE

		-Authorized Debit (PAD) y") to withdraw the required						eement	Form	(page	3), auth	norizing	Indust	trial <i>A</i>	Alliance	Insuran	e and	Financial	Services In	ı
	month. I under	dit Card — I authorize the restand this amount may char effective date. The monthly co	ige at a future date as	s specifie	d in the I	Master Gro	up Poli	y. The O	Compar	ny will,	, to the									
Į	OR	Cardholder Name		Cred	it Card N	lumber										Expiry	Date (m	nmm-yyy	у)	
	MasterCard																			_
1.	This offer is on above which can above which are above and the standard that is diagnosed with as any signs, so ancer (Life-Thr made. If the instance but Beniguer)	ZATION IMPORTA Illy available to eligible me annot be extended. Inat no benefit will be paya IdvanceCare Benefit Condi fective date of coverage whie Existing Condition" means sorder for which any one of gnosis or consultation, includ is has not yet been made) v rudent individual within the e. In the Benign Brain Tumour, Ca tymptoms or investigations t reatening) or Early Stage Care sured continues to satisfy the In Brain Tumour and Cancer tions and Early Stage Cancer tions and Early Stage Cancer	ble if an insured is often within the first ch results directly or in illness, disease, mer f medical advice, treading consultation to in vas received by the in 24 months immediat if, within the first 90 dincer (Life-Threatening hat lead to a diagnosticer, regardless of where eligibility provision (Life-Threatening) wi	diagnosed 24 mo directly for the later of th	d with a nths imi rom a Proous or p service, pe, and/or would hiding the werage, a y Stage (aign Brain agnosis inge will inger be co	Covered mediately e-Existing sychiatric prescribed diagnose ave been effective in insured Cancer or in Tumour, is actually remain in possidered	3. I a 4. I si ir 5. I u iss Ir sl 6. I b	have no nd unde acknov ummariz formati agree to ndersta option surance nown ou	ot made erstand vledge zing cer on. o the us nd that al, and e and F n this a and that	e any r that if that rtain p se of m my co that if inancia pplica at cove //, prov	misrepro f I have I have rivacy p ny perso onsent t I wish al Servi tion. erage w	esentatic done so read the rractices conal info to the us to discor ces Inc.	ons reons reons reons reons reons regardermation of antinue (the "	gardierage otice ding in such formal comments on the comments of the comments on the comments of the comments	ing ago may be on Pr collect or the participant and use I apany"	e, gender, be void. ivacy and ion, use a burposes tion to of may call () at the to	smokind Confind discoutlined for me por write elephon	ine date ing status identialit losure of d in this a products to Indus ie numbe		d i. e c

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Date (dd-mmm-yyyy)

Spouse Signature (if applying)

Date (dd-mmm-yyyy)

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PRE-AUTHORIZED DEBIT (PAD) AGREEMENT

STEP 1 - PROVIDE DETAILS FOR MONTHLY PRE-AUTHORIZED DEBITS

ACCOUNT DETAILS						
Name(s) of Account Holder(s) as shown on Finance	cial Institution records					
Street Address of Account Holder(s)	City		Prov.	Postal Code		
Name of Financial Institution		L				
Street Address of Branch	City		Prov.	Postal Code		
Financial Institution Number	Transit Number	Account Number				
ACCOUNT DETAILS (see sample below)						
MEMO						
	1 1 1 1 5). 				
11 5 1 11 + 11 2 3 4 5 11 6 7	8: 12345-6789	Ji-				
Transit #						
Cheque # Institut	tion # Account #					
STEP 2 - REVIEW AND PROVIDI	E AUTHORIZATION					
WITHDRAWAL ARRANGEMENT						
☐ Fixed Variable						
RECOURSE						
/ou have certain recourse rights if any debit does	not comply with this agreement. For exam	nple, you have the right to receive reimbursement for any act your financial institution or visit www.cdnpay.ca.	y debit that is	not authorized or is no		
AUTHORIZATION FORM MUST BE	· · · · · · · · · · · · · · · · · · ·	ace your mandar institution of visit www.campay.ca.				
/we, as the Account Holder(s), authorize Industrial Allia "Company") and the financial institution named above on withdraw variable monthly payments from my/our account of collecting premiums and any applicable sales tax	or as indicated on the attached 'VOID' cheque, count, at the branch indicated, for the purpose service charges for insurance under this policy.	I/we may cancel this PAD Agreement at any time, Company at the address provided below. This notifica business days before the next debit is scheduled. I/v form, or more information on my/our right to cancel institution or by visiting www.cdnpay.ca.	ntion must be r we may obtain	received at least ten (10 n a sample cancellatio		
The PAD amount will be debited from the account indica next business day. I/we agree to notify the Company in information set out above.	writing, if there is any change to the banking	 I/we understand that cancellation of this PAD Agreement will not have any effect on provided under this policy, provided that payment is received when due and is made in ac the terms of this policy. This PAD Agreement only applies to the method of payment. I/we understand that compl Agreement does not mean that the application for insurance coverage has been approved. 				
/we waive the right to receive pre-notification of the am such debit. I/we agree that the Company will provide w three (3) calendar days before the first PAD is debited debited, except when the increase is due to a change in the PAD amount is a result of my/our request.	ritten notice of the amount of the PAD at least and before any increase to the PAD amount is					
X		X				
Member Signature (must always sign)	Date (dd-mmm-yyyy)	Signature of all other Account Holder(s) (if a required signatory to this account)) Da	te (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:



QUESTIONS?

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)

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