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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

GROUP CRITICAL ILLNESS INSURANCE APPLICATION FOR LATE APPLICANTS

Please complete, print and sign.

POLICY INFORMATION THIS SECTION TO BE COMPLETED BY THE POLICYHOLDER

Name of Policyholder/Employer | Policy Number | Division Number

Reason for Late Application

Amount of Critical Illness Insurance applying for

Is the Employee actively at work and physically able to perform each and every duty of his/her employment? ○ Yes ○ No

If "No", please provide details:

Policyholder Authorized Representative Name | Title

X

Policyholder Authorized Representative Signature (must always sign) | Date (dd-mmm-yyyy)

EMPLOYEE INFORMATION THIS SECTION TO BE COMPLETED BY THE EMPLOYEE

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

Place of Birth | Occupation | Date of Employment (dd-mmm-yyyy)

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

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

EMPLOYEE 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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HEALTH AND LIFESTYLE QUESTIONS MUST ALWAYS BE COMPLETED WHEN APPLYING

	If you answer "Yes" to questions 2-22 (or "No" to question 7), please complete the Additional Details section below.	Employee Yes	Employee No
1)	**Employee:** **Height:** ☐ feet/inches ☐ cm **Weight:** ☐ lbs ☐ kgs		
2)	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.	☐	☐
3)	Have you flown as a pilot, student or crew member in the last two years or do you have any intention to do so?	☐	☐
4)	Have you engaged in or do you intend to participate in scuba diving, parachuting or other hazardous sport or activity?	☐	☐
5)	Do you intend to travel or reside outside Canada or the United States for more than a month?	☐	☐
6)	Have you had a request for life, disability or critical illness insurance declined, postponed, rated or modified in any way?	☐	☐
7)	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.	☐	☐
8)	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?	☐	☐
9)	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?	☐	☐
10)	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?	☐	☐
11)	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?	☐	☐
12)	Have you ever used marijuana, heroin, morphine, cocaine, LSD, barbiturates, amphetamines, or any other drug or narcotic, except as prescribed by your physician?	☐	☐
13)	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?	☐	☐
14)	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?	☐	☐
15)	Are you taking any prescribed medication? If "Yes", state name of medication and reason for use.	☐	☐
16)	Are you aware of any symptoms or complaints regarding your health for which you have not yet consulted a physician or received treatment?	☐	☐
17)	Have you been absent from work for more than seven consecutive days within the past year due to sickness or injury?	☐	☐
18)	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.	☐	☐
19)	Females only: Are you currently pregnant? If "Yes", please provide your estimated due date and advise of any complications with current or past pregnancies.	☐	☐
20)	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?	☐	☐
21)	Have you ever received or claimed benefits or a pension for sickness, injury or impairment?	☐	☐
22)	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 YOU ANSWER "YES" TO ANY QUESTION OR "NO" TO QUESTION 8, PROVIDE DETAILS BELOW

Question Number	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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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?

Yes ○ **No** ○

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

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

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 _____ _____

Employee Signature (must always sign) | 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: 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