Request for Non-Smoker Rates

For Office Use Only

Please print in ink

To be eligible for Non-Smoker Rates, you must not have smoked cigarettes, cigars, cigarillos, pipe, marijuana, or used snuff, chewing tobacco or nicotine products (gum, patches etc.) within the past 12 months and must provide satisfactory evidence of insurability.

Policy Information

Policy No. | Division No. | Name of Policyholder/Association

Please Tell Us About Yourself

Member/Employee Information *(Must always be completed)*

Last Name | Given Name | Initials | Member/Employee ID

Spouse Information *(Only complete if applying)*

Last Name | Given Name | Initials

Mailing Address

Street | City

Prov. | Postal Code | Phone Number (Home) | Phone Number (Work) | E-mail Address

Please Answer These Lifestyle Questions

	Member/ Employee		Spouse		Please provide details of "Yes" answers including dates, durations, etc. If you require more space, please attach a separate sheet of paper, signed and dated.	
	Yes	No	Yes	No	Member/Employee Details	Spouse Details
1. a) Have you smoked any cigarettes, cigars, cigarillos, pipe or used snuff, chewing tobacco, or nicotine products (patch, gum etc.) within the past **12 months**?	❑	❑	❑	❑		
b) Have you used marijuana or similar agents within the past **12 months**?	❑	❑	❑	❑		
2. Have you **ever** used any of the items listed in Question 1? If "Yes", what products and when did usage stop?	❑	❑	❑	❑		
3. Are you involved in the operation of an aircraft or involved in scuba diving, parachuting or any other hazardous sport?	❑	❑	❑	❑		
4. What is your present occupation? Give details of any proposed changes.						

Please Answer These Health Questions

	Member/ Employee		Spouse		Please provide details of "Yes" answers including dates, reasons, durations and names and addresses of all doctors, hospitals, etc. If you require more space, please attach a separate sheet of paper, signed and dated.	
5. Height						
6. Weight						
	Yes	No	Yes	No	Member/Employee Details	Spouse Details
7. Since your insurance coverage was issued – a) Have you ever had or have you ever been treated for cancer, cyst, tumour or any form of malignant disease, abnormal ECG, chest pain, angina, heart attack, diabetes, disorder of the thyroid, pancreatitis or other endocrine disease or disorder, a blood, heart, lung, kidney or liver disorder, high blood pressure, epilepsy, a mental or nervous system disorder, stress, anxiety or depression, multiple sclerosis, amyotrophic lateral sclerosis (ALS), hepatitis, cirrhosis, stomach or any other intestinal disorder, stroke, paralysis, transient ischemic attack (TIA), ulcer or any disorder of the eyes, ears, vocal cord or larynx including loss of speech?	❑	❑	❑	❑		
b) Have you ever been treated for or diagnosed with AIDS (Acquired Immune Deficiency Syndrome), ARC (Aids Related Complex), HIV (Human Immune Deficiency Virus), sexually transmitted disease, enlargement of lymph nodes (glands), chronic diarrhea, Ulcerative Colitis, Crohn's disease, unusual skin lesions or unexplained infections or other immunological disorder, other physical changes or abnormal biopsy or mammogram findings?	❑	❑	❑	❑		
c) Have you any condition for which hospitalization, further testing, investigation or surgery has been advised, or which have not yet been done?	❑	❑	❑	❑		
d) Do you have any reason to believe you are suffering from any disorder, or are you taking any prescribed medication?	❑	❑	❑	❑		
e) Have you consulted a physician or received treatment for any disease, disorder, ailment or injury not already mentioned?	❑	❑	❑	❑		
f) Have you ever had a request for life, critical illness or health insurance declined, postponed, rated, or restricted in any way? If "Yes" give reason.	❑	❑	❑	❑		

Detach Here

Please turn over and complete reverse side

Notice on Privacy and Confidentiality *(Please Read Carefully and Detach 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 Pacific Insurance and Financial Services Inc. ("IAP") employees, its reinsurers, third party administrators, mandataries, agents or brokers of IAP, plan sponsors and any agents or brokers of such sponsors or other market intermediaries who are responsible for (a) sponsoring a plan for you, (b) marketing and administration of products or services, (c) assessment of risk (underwriting) and (d) investigation of claims. **Your file will be kept in IAP's 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, B.C. V6B 5H6, Attention: Manager, Group Administration, Special Markets Group. 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 at our website www.iapacific.com or alternatively, contact us at 1-800-266-5667 and request that a copy be faxed or mailed to you.

Underwritten by:
Industrial Alliance Pacific Insurance and Financial Services Inc., Special Markets Group, 2165 Broadway W, P.O. Box 5900, Vancouver, BC V6B 5H6, **1-800-266-5667, group@iapacific.com**

Who Is Your Personal Physician?

Name, address and phone number of Member/Employee's personal physician	Name, address and phone number of Spouse's personal physician
Date and reason last consulted any doctor	Date and reason last consulted any doctor
Diagnosis, treatment or medication prescribed	Diagnosis, treatment or medication prescribed

Here's the Fine Print — Please Give Us Your Authorization

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 Pacific Insurance and Financial Services Inc. ("IAP") or its reinsurers any such information for the purpose of the risk assessment, administration or investigation of a subsequent claim.

b) IAP 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) IAP 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) IAP 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 confirm that the foregoing answers, forming part of an application for group insurance to Industrial Alliance Pacific Insurance and Financial Services Inc. ("IAP") 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 IAP 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 IAP and the first month's premium has been paid.

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

Member/Employee Signature (must always sign) — *Date Signed (dd/mmm/yyyy)*

Spouse Signature (when applying for non-smoker rates) — *Date Signed (dd/mmm/yyyy)*

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Disclosure Notice *(Please Read Carefully and Detach For Your Records)*

Information regarding your insurability will be treated as confidential. Industrial Alliance Pacific Insurance and Financial Services Inc. ("IAP") and its reinsurers may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such company, the Bureau, upon request, will supply that company with the information it may have in its files.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction. The address of the Bureau's Information office is: Medical Information Bureau, 330 University Avenue, Toronto, Ontario, Canada M5G 1R7, telephone number (416) 597-0590.

IAP 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.