



For Office Use Only

Application for Extended Health & Dental Insurance

Please print in ink

Policy Information

Group Policy No.: _____ Name of Policyholder/Association: _____

ELIGIBILITY: Alumni Members are eligible to apply. The Member must apply for the Spouse and Dependent Children to be eligible for coverage. All persons to be insured must be residing in Canada and enrolled in a Provincial Health Plan. Members and Spouses must be less than 61 years of age and Dependent Children less than 25 years of age at the time of application. Residents of Quebec must have basic prescription drug coverage by RAMQ, their employer or otherwise.

Please Tell Us About the Individuals to be Covered

Last Name/First Name	Health Card Number	Gender (M/F)	Birth Date (dd/mm/yyyy)	Age	Smoker? (Yes/No) <small>If 'yes' please include # of cigarettes smoked daily</small>	Height (cm/inch)	Weight (kg/lb)	Weight Change in Last Year (Gain or Loss)	Reason for Weight Change
MEMBER									
SPOUSE									
DEPENDENT CHILD									
DEPENDENT CHILD									
DEPENDENT CHILD									

Mailing Address
Street _____ City _____

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

Tell Us About The Insurance You Want

- Basic Plan – Health Only Basic Plan – Health & Dental
 Comprehensive Plan – Health Only Comprehensive Plan – Health & Dental

Note: Family members must be insured under the same plan.

General Information

Are you now covered or did you have previous health insurance coverage with IAP or any other insurance company? Yes No
If "Yes" please indicate:

Plan Number	ID Number	Insurance Company	Date Benefits Ended
Plan Number	ID Number	Insurance Company	Date Benefits Ended

Is this application intended to replace your current coverage? Yes No

Who Is Your Personal Physician?

Primary Health Care Provider	Member	Spouse	Dependent(s)
Name of Primary Health Care Provider			
Address and Telephone Number of Primary Health Care Provider			
Date of Last Consultation			
Reason			
Diagnosis made			
Treatment given			

Member Signature **(must always sign)** _____ Date _____

Spouse Signature (when applying for insurance) _____ Date _____

Member Name **(please print)** _____

Spouse Name (please print) _____



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Please Answer These Health/Lifestyle Questions

If you answer "Yes" to questions 1 to 5 below, please give details in the chart provided in question 6.		Yes	No
1.	Have you, your Spouse or any listed Dependent Children ever consulted a Physician about, been treated for, or had any known indication of:		
a)	High blood pressure, stroke, transient ischemic attack (TIA), chest pain, angina, high cholesterol or other heart or circulatory disorders, dizziness, fainting or blood disorder?	<input type="checkbox"/>	<input type="checkbox"/>
b)	Back, joint or any musculoskeletal pain or disorder, arthritis or rheumatism?	<input type="checkbox"/>	<input type="checkbox"/>
c)	Digestive system disorder, liver disease or disorder including hepatitis?	<input type="checkbox"/>	<input type="checkbox"/>
d)	Depression, stress, mental, emotional or nervous disorder?	<input type="checkbox"/>	<input type="checkbox"/>
e)	Alcohol or drug abuse?	<input type="checkbox"/>	<input type="checkbox"/>
f)	Asthma, allergy, respiratory disorder, or shortness of breath?	<input type="checkbox"/>	<input type="checkbox"/>
g)	Immune disorder including testing for Acquired Immune Deficiency Syndrome (AIDS), Human Immunodeficiency Syndrome (HIV)?	<input type="checkbox"/>	<input type="checkbox"/>
h)	Cancer, tumour or any growth?	<input type="checkbox"/>	<input type="checkbox"/>
i)	Skin disorder?	<input type="checkbox"/>	<input type="checkbox"/>
j)	Infertility, reproductive disorder or menopause?	<input type="checkbox"/>	<input type="checkbox"/>
k)	Bladder, kidney or other genitourinary disorder?	<input type="checkbox"/>	<input type="checkbox"/>
l)	Headaches, migraines, eye or ear disorder?	<input type="checkbox"/>	<input type="checkbox"/>
m)	Diabetes or other endocrine disorder?	<input type="checkbox"/>	<input type="checkbox"/>
n)	Other condition, disease or disorder not mentioned above? If "Yes", please specify: _____	<input type="checkbox"/>	<input type="checkbox"/>
2.	Have you, your Spouse or any listed Dependent Children ever been treated for, hospitalized or had any physical impairment, congenital abnormality, medical condition, disease or disorder not stated above? If "Yes", please specify whom and provide details below.	<input type="checkbox"/>	<input type="checkbox"/>
3.	Have you, your Spouse or any listed Dependent Children ever been advised to have an investigation, hospitalization or surgery which has never been completed? If "Yes", please specify whom and provide details below.	<input type="checkbox"/>	<input type="checkbox"/>
4.	Have you, your Spouse or any listed Dependent Children been disabled and/or unable to perform normal daily activities from any cause for at least 2 consecutive weeks within the last 5 years?	<input type="checkbox"/>	<input type="checkbox"/>
5.	Are you, your Spouse or any listed Dependent Children pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
6.	If you answered "Yes" to any of the above questions, please give details. If you need more space, please attach a separate piece of paper, signed and dated.		

Ques. #	Name of Person to be Insured	Nature of Disorder	Duration and Date	Result	Attending Physician or Hospital

7. List all medications or other treatment (therapy, counselling, etc.) that any individual to be insured is currently taking, or expects to be taking, or that has been prescribed within the past 12 months, including unfilled prescriptions. If you need more space, please use a separate sheet of paper, signed and dated.
Note: Please do not include medications used to treat minor ailments like cold or flu.

Name of Person to be Insured	Medication or Treatment	Date Prescribed DD/MM/YY	Dosage and Frequency	Monthly Cost	Date Discontinued (If Applicable) How long used?	Reason for use

Member Signature (**must always sign**) _____ Date _____

Spouse Signature (when applying for insurance) _____ Date _____

Member Name (**please print**) _____

Spouse Name (please print) _____



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Premium Payment Options – Please Choose One:

Note: If you are currently insured, the same payment method will apply to all coverage.

- Cheque** – I have attached a cheque for the first month's premium payable to "Industrial Alliance Pacific". I understand the balance of the premium (plus applicable taxes) will be billed once my coverage is approved.
- Credit Card** – I authorize IAP to charge the required premium (plus applicable taxes) to the credit card indicated below.
- Monthly Pre-Authorized Debit (PAD)** – I have attached a completed Pre-Authorized Debit (PAD) Agreement form authorizing IAP to withdraw the required premium (plus applicable taxes) from my account. (To obtain a form please visit www.iapacific.com/PADform).
- Monthly Credit Card** – I authorize IAP to charge the required monthly premium (plus applicable taxes) to the credit card indicated below on or around the 1ST day of each month. I understand this amount may change at a future date as specified in the Master Group Policy. IAP will, to the best of its ability, advise me in writing of the revised amount in advance of its effective date. The Monthly Credit Card option may be discontinued by me or IAP upon written notice.



OR



Cardholder Name

Credit Card Number

Expiry Date

(M M / Y Y Y Y)

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

I acknowledge receipt of the Disclosure Notice (Page 5) 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 (Page 5) 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 IAP 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 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 Signature (must always sign) _____ Date _____

Spouse Signature (when applying for insurance) _____ Date _____

Member Name (please print) _____

Spouse Name (please print) _____



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Retain for Your Records

Notice on Privacy and Confidentiality

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.

DISCLOSURE NOTICE – Medical Information Bureau

(Please Read Carefully and Retain 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.



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Underwritten by:

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