



Application for Voluntary Group Insurance

For Office Use Only

Please print in ink

Policy Information

Policy No. _____ Name of Policyholder/Association _____ Who is Applying for Coverage: Alumnus Spouse Employee/Faculty Student

Please Tell Us About Yourself

Member Information (Must always be completed)

Last Name _____ Given Name _____ Initials _____

Sex M F Date of Birth _____ Place of Birth _____
(d d / m m m / y y y y y) Province, State or Country

Occupation _____ Are you currently insured under this plan? Yes No
If 'Yes', give Member/Employee ID _____

Do you have any other insurance with IAP? Yes No
If 'Yes', please give details (type of policy, amount of coverage, etc.) _____

Spouse Information (Must be completed when applying)

Last Name _____ Given Name _____ Initials _____

Sex M F Date of Birth _____ Place of Birth _____
(d d / m m m / y y y y y) Province, State or Country

Occupation _____ Are you currently insured under this plan? Yes No
If 'Yes', give Member/Employee ID _____

Do you have any other insurance with IAP? Yes No
If 'Yes', please give details (type of policy, amount of coverage, etc.) _____
Note: If Spouse is an eligible Alumnus, he/she must complete a separate application form.

Mailing Address

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

Tell Us About the Insurance You Want

Member Benefits - Do Not Include any Benefit Amounts Already in Force Under this Group Policy

Member Term Life Insurance

Amount desired: \$ _____
(Units of \$25,000, maximum \$350,000)

Accidental Death & Dismemberment Insurance

Available only if the Member is insured for Member Term Life or Critical Illness Insurance
 Member Only Plan Member and Family Plan
Amount desired: \$ _____
(Units of \$25,000, maximum \$350,000)

Office Overhead Insurance

Waiting Period: 30 days 60 days
Amount desired: \$ _____
Units of \$100 (minimum \$500), maximum \$5,000 per month;
subject to a maximum of 100% of your eligible business expenses

Member Critical Illness Insurance

Amount desired: \$ _____
(Units of \$25,000, maximum \$300,000)

Dependent Children Term Life Insurance

Available only if the Member is insured for Member Term Life Insurance
Amount desired: \$ _____
(Units of \$5,000, maximum \$20,000)

Long Term Disability Insurance

Available only if the Member is insured for Member Term Life Insurance
Waiting Period: 30 days 120 days 180 days
Cost of Living Adjustment (COLA): With COLA Without COLA
Amount desired: \$ _____
Units of \$100 (minimum \$500), maximum \$3,500 per month;
subject to a maximum of 50% of gross monthly earnings

Spousal Benefits - Do Not Include any Benefit Amounts Already in Force Under this Group Policy

Spouse Term Life Insurance

Amount desired: \$ _____
(Units of \$25,000, maximum \$350,000)

Spouse Critical Illness Insurance

Amount desired: \$ _____
(Units of \$25,000, maximum \$300,000)

Member - Please Name Your Beneficiary

The beneficiary designation stated on this application will supersede all prior dated revocable designations and will apply in the event of the Member's death, to benefits payable under the Member Term Life and Accidental Death & Dismemberment Insurance under the group policy unless specific written instructions to the contrary have been received by IAP. You may change your beneficiary at any time without the beneficiary's consent, unless you specifically designate your beneficiary as irrevocable. (Quebec residents, please see * below.)

Last Name _____ Given Name _____ Initials _____ Relationship to Member _____

If you are naming a beneficiary who is under the age of 18, you should name a Trustee to receive the monies in trust for the beneficiary.

Name of Trustee for any Minor beneficiary: _____

All other benefits are payable to the Member, including benefits payable under **Spouse and Dependent Children Term Life** insurance unless otherwise stated in writing.

* **Quebec Residents:** If you designate your spouse as your beneficiary, this designation is irrevocable unless you check this box. **Revocable**

Member Signature (must always sign) _____ Date _____

Spouse Signature (when applying for insurance) _____ Date _____

Member Name (please print) _____
FORM 4211 WEB (APR/2010)

Spouse Name (please print) _____



Please Answer These Lifestyle/Health Questions

Questions 1 to 21 must be answered when applying for Term Life Insurance, and/or Critical Illness Insurance, and/or Long Term Disability and/or Office Overhead Insurance. If applying for Accidental Death and Dismemberment Insurance you need only complete questions 2 to 6. If applying for Dependent Children Term Life Insurance, please complete question 22.

Form with columns for Member, Spouse, and Member/Spouse Details. Includes questions 1-22 regarding health, lifestyle, and dependent children coverage.

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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Tell Us About Your Family History

Have any of your natural parents, brothers or sisters ever suffered from any of the following conditions: Heart attack, angina, bypass surgery 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?

Member Spouse
 Yes No 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)	
	Member	Spouse	Member	Spouse	Member	Spouse
Father						
Mother						
Brothers/ Sisters						

Who is Your Personal Physician?

Name, address and phone number of Member's personal physician

Reason and date last consulted any Doctor.

Diagnosis, treatment or medication prescribed

Name, address and phone number of Spouse's personal physician

Reason and date last consulted any Doctor.

Diagnosis, treatment or medication prescribed

Business Questionnaire – Must be completed when applying for Office Overhead Insurance

Date you started your business:

(D	D	/	M	M	/	Y	Y	Y	Y)

Average Number of hours worked each week: _____
 If less than 30 hours per week, please attach explanation.

What is your share in the business expenses: _____ %

Your gross annual income earned before business expenses : \$ _____ (a)

Total annual business expenses : \$ _____ (b)

Net annual income before taxes : \$ _____ (a - b)

What is your estimated annual income tax?: \$ _____

Excluding salary, fees, drawing account, or any other remuneration for yourself, or the cost of goods, wares and merchandise of any nature, or the cost of implements for your profession or occupation, what was the average **monthly** expense personally incurred by you during the preceding six months for:

- | | | |
|------------------------|--------------------------------|-----------------------------|
| • rent \$ _____ | • laundry \$ _____ | • other expenses (specify): |
| • electricity \$ _____ | • depreciation \$ _____ | _____ \$ _____ |
| • telephone \$ _____ | • employees' salaries \$ _____ | _____ \$ _____ |
| • heat \$ _____ | • automobile \$ _____ | _____ \$ _____ |
| • water \$ _____ | • professional dues \$ _____ | _____ \$ _____ |

If you require more space, please attach a separate sheet of paper, signed and dated.

Total Fixed Expenses: \$ _____

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

Spouse Signature (when applying for insurance) _____ Date _____

Member Name (please print) _____

Spouse Name (please print) _____



Income Questionnaire – Must be completed when applying for Long Term Disability Insurance

- 1. Gross Monthly Earnings \$
Note: Gross Monthly Earnings means income earned from your employment or profession...
2. Monthly Take Home Pay \$
Note: Monthly Take Home Pay means Gross Monthly Earnings less Federal and Provincial taxes...
3. Will any income be continued by your employer during disability or as a result of a partnership agreement?
4. Have you ever applied for or do you have other Long Term Disability insurance in force?

Table with 5 columns: Name of Coverage Provider, Individual or Group, Effective Date, Monthly Benefit, Benefit Period

If any of the above coverage will be terminated, give details:

Premium Payment Options – Please Choose One

- Note: If you are currently insured, the same payment method will apply to all coverage.
Cheque
Credit Card
Monthly Pre-Authorized Debit (PAD)
Monthly Credit Card

Form for credit card information including MasterCard and VISA logos, Cardholder Name, Credit Card Number, and Expiry Date.

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...
b) IAP or its reinsurers to release and exchange any personal information...
c) IAP to test and evaluate a specimen of my blood, urine or saliva...
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.

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)
FORM 4211 WEB (APR/2010)

Spouse Name (please print)



NOTICE ON PRIVACY AND 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 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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