

**ATA Voluntary Benefits Program**  
**APPLICATION FOR GROUP CRITICAL ILLNESS INSURANCE**  
**COVERAGE SUBJECT TO EVIDENCE OF INSURABILITY**



*For Office Use Only*

Policy No. 100007680

**Member/Spouse Information**

| Member Information <i>(Must always be completed)</i>  |                      |   | Spouse Information <i>(Must be completed when applying)</i>                                  |   |   |
|---|----------------------|---|--|---|---|
| Last Name   | Given Name           | Initial(s)                                | Last Name  | Given Name  | Initial(s)                                |
| <input type="text"/>  | <input type="text"/> | <input type="text"/>                      | <input type="text"/>   | <input type="text"/>  | <input type="text"/>                      |
| Are you an ATA Member? <input type="checkbox"/> Yes <input type="checkbox"/> No               |                      |   | Spouse: Are you also an ATA Member? <input type="checkbox"/> Yes <input type="checkbox"/> No |   |   |
| <b>Note:</b> if spouse is also an ATA Member he/she must complete a separate application form |                      |   |  |   |   |
| Sex   | Date of Birth        | Place of Birth                            | Sex  | Date of Birth   | Place of Birth                            |
| <input type="checkbox"/> M<br><input type="checkbox"/> F                                      | <input type="text"/> | <input type="text"/>                      | <input type="checkbox"/> M<br><input type="checkbox"/> F                                     | <input type="text"/>  | <input type="text"/>                      |
| <small>( D D / M M / Y Y Y Y )</small>  |                      | <small>Province, State or Country</small> | <small>( D D / M M / Y Y Y Y )</small>   |   | <small>Province, State or Country</small> |
| Occupation  | Height               | Weight                                    | Occupation   | Height  | Weight                                    |
| <input type="text"/>  | <input type="text"/> | <input type="text"/>                      | <input type="text"/>   | <input type="text"/>  | <input type="text"/>                      |
| Mailing Address   |                      |   |  |   |   |
| Street  |                      |   | City   |   |   |
| <input type="text"/>  | <input type="text"/> | <input type="text"/>                      | <input type="text"/>   | <input type="text"/>  | <input type="text"/>                      |
| Prov.   | Postal Code          | Phone Number (Home)                       | Phone Number   | <input type="checkbox"/> Work <input type="checkbox"/> Cell | E-mail Address                            |
| <input type="text"/>  | <input type="text"/> | <input type="text"/>                      | <input type="text"/>   | <input type="text"/>  | <input type="text"/>                      |

**Tell Us About The Insurance You Want**

| Member   | Spouse   |
|--|--|
| Coverage Amount \$ <input type="text"/>                  | Coverage Amount \$ <input type="text"/>                  |
| <small>Units of \$25,000 to maximum of \$300,000</small> | <small>Units of \$25,000 to maximum of \$300,000</small> |

**Do not include any Critical Illness coverage already in force.**

**Who Is Your Personal Physician? (Must be completed by Member and/or Spouse if applying)**

| Member  | Spouse  |
|---|---|
| Name, address and phone number of Member's personal physician | Name, address and phone number of Spouse's personal physician |
| <input type="text"/>  | <input type="text"/>  |
| <input type="text"/>  | <input type="text"/>  |
| Date and reason last consulted <u>any</u> doctor              | Date and reason last consulted <u>any</u> doctor              |
| <input type="text"/>  | <input type="text"/>  |
| Diagnosis, treatment or medication prescribed                 | Diagnosis, treatment or medication prescribed                 |
| <input type="text"/>  | <input type="text"/>  |

**Tell Us About Your Family History (Must be completed by Member and/or Spouse if applying)**

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?

|  |  |
|--|--|
| <b>Member</b>  | <b>Spouse</b>  |
| Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |

**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               |
| <b>Father</b>                | <input type="text"/> | <input type="text"/> | <input type="text"/>     | <input type="text"/> | <input type="text"/>         | <input type="text"/> |
| <b>Mother</b>                | <input type="text"/> | <input type="text"/> | <input type="text"/>     | <input type="text"/> | <input type="text"/>         | <input type="text"/> |
| <b>Brothers/<br/>Sisters</b> | <input type="text"/> | <input type="text"/> | <input type="text"/>     | <input type="text"/> | <input type="text"/>         | <input type="text"/> |

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Policy No. 100007680

**Please Answer These Health/Lifestyle Questions (Must be completed by Member and/or Spouse if applying)**

| Please provide details of "Yes" answers<br>including dates, duration, and names and addresses of all doctors, hospitals, etc.   | Member                   |                          | Spouse                   |                          | If you require more space, please attach a separate sheet of paper, signed and dated   |                |                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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|   | Yes                      | No                       | Yes                      | No                       |  |                |                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 1. Have you smoked any cigarettes, cigars, cigarillos, pipe or used snuff, chewing tobacco or nicotine products (patch, gum, etc.) within the past <b>12 months</b> ?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 50%; text-align: center;">Member Details</th> <th style="width: 50%; text-align: center;">Spouse Details</th> </tr> </thead> <tbody> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> </tbody> </table> | Member Details | Spouse Details |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Member Details  | Spouse Details           |                          |                          |                          |  |                |                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| 2. Have you flown as a pilot, student or crew member in the last two years or do you have any intention to do so?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |  |                |                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 3. Have you engaged in or do you intend to participate in scuba diving, parachuting or other hazardous sport or activity?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |  |                |                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 4. Do you intend to travel or reside outside Canada or the United States for more than a month? If "Yes", please provide details.   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |  |                |                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 5. Have you had a request for life, disability or critical illness insurance declined, postponed, rated or modified in any way? If "Yes", please provide details.   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |  |                |                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 6. Are you now actively engaged in your occupation on a full-time basis?<br>If "No", please provide details including reason why you are not working on a full-time basis.  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |  |                |                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 7. 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?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |  |                |                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 8. 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? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |  |                |                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 9. 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?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |  |                |                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 10. 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?                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |  |                |                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 11. Have you ever used marijuana, heroin, morphine, cocaine, LSD, barbiturates, amphetamines, or any other drug or narcotic, except as prescribed by your physician?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |  |                |                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 12. a) Do you presently drink more than 10 alcoholic beverages per week?<br>If "Yes", state number, kind and frequency.   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |  |                |                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 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?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |  |                |                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 13. 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?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |  |                |                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 14. Are you taking any prescribed medication? If "Yes", state name of medication and reason for use.  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |  |                |                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 15. Are you aware of any symptoms or complaints regarding your health for which you have not yet consulted a physician or received treatment?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |  |                |                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 16. Have you been absent from work for more than seven consecutive days within the past year due to sickness or injury?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |  |                |                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 17. 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.  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |  |                |                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 18. Females only: Are you pregnant or have you ever had complications of pregnancy?<br>If pregnant, what is your estimated date of delivery?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |  |                |                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 19. During the past 10 years, have you consulted a physician, received treatment or been hospitalized, had surgery or any test ( <b>other than routine checkup or minor injury</b> ) for any disease, disorder or ailment not already mentioned?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |  |                |                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 20. Have you ever received or claimed benefits or a pension for sickness, injury or impairment?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |  |                |                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 21. Have you been convicted of a criminal offense, had your driver's license suspended, or within the past three years, been convicted of more than three traffic violations?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |  |                |                |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

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**APPLICATION FOR GROUP CRITICAL ILLNESS INSURANCE**  
**COVERAGE SUBJECT TO EVIDENCE OF INSURABILITY**



Policy No. 100007680

**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](http://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 1<sup>ST</sup> 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 (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 (enclosed) 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 providing the Member is actively at work on that date 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 (dd/mmm/yyyy)

\_\_\_\_\_  
 Spouse Signature (when applying)

\_\_\_\_\_  
 Date (dd/mmm/yyyy)

**ATA Voluntary Benefits Program**  
**APPLICATION FOR GROUP CRITICAL ILLNESS INSURANCE**  
**COVERAGE SUBJECT TO EVIDENCE OF INSURABILITY**



Policy No. 100007680

**Notice on Privacy and Confidentiality**

**Notice to Applicant – Please Read Carefully**

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 Industrial Alliance Pacific, 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](http://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**

**Notice to Applicant – Please Read Carefully**

Information regarding your insurability will be treated as confidential. Industrial Alliance Pacific Insurance and Financial Services ("IAP") and its reinsurers may, however, make a brief report thereon to the Medical Information Bureau, a nonprofit 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.



***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](mailto:group@iapacific.com)