iA Financial Group

# Evidence of insurability

GROUP INSURANCE

**General information *(Please print in ink)***

Policyholder's name (Employer/organization) _____

Group policy no. _____ Division no. _____ Class no._____ Certificate no. _____

Member's last name _____ First name _____

Employment date Y M D Eligibility date Y M D Annual salary $_____

**1. Reason for completing this form**

☐ Applying for optional benefits

☐ Applying for an additional amount of insurance which exceeds the maximum amount specified by the plan:

☐ Basic Life ☐ Disability Income ☐ Critical Illness

☐ Plan member late enrolment in group insurance plan

☐ Dependents late enrolment in group insurance plan. If the spouse (and the children, if any) is or was covered under another group insurance plan, please specify the following:

Insurer's name_____ Group policy no. _____ Certificate no. _____

Date and reason of the coverage termination, if any _____

☐ Other, specify _____

**2. Coverage requested for the benefit(s) listed below**

**Please see the group insurance contract to complete this table.**

| Benefits | Current Insurance Amount | Additional Insurance Amount Requested | Total |
|---|---|---|---|
| Critical Illness | | | |
| 1. Member | $ | $ | $ |
| 2. Spouse | $ | $ | $ |
| 3. Children[1] | $ | $ | $ |
| Basic Life | | | |
| 1. Member | $ | $ | $ |
| 2. Spouse | $ | $ | $ |
| 3. Children[1] | $ | $ | $ |
| Optional Life | | | |
| 1. Member | $ | $ | $ |
| 2. Spouse | $ | $ | $ |
| 3. Children[1] | $ | $ | $ |
| Short-term disability | $ | $ | $ |
| Long-term disability | $ | $ | $ |
| Health | ☐ Individual ☐ Family ☐ Single parent ☐ Couple | | |
| Dental | ☐ Individual ☐ Family ☐ Single parent ☐ Couple | | |

[1] Each child will benefit from the insurance amount you selected.

Plan member's name _____ Group policy no. _____ Certificate no. _____

**The following pages must be completed and signed by the plan member and the dependents, if applicable.** ***(Please print in ink.)***

**Important:** Please provide the information requested for the proposed insureds only.

## PLAN MEMBER INFORMATION

Height _____ ☐ ft/in ☐ m/cm Weight _____ ☐ lb ☐ kg Sex ☐ M ☐ F

Date of birth: Y M D Place of birth _____

Occupation _____

Telephone no. _____ Email _____

Do you have an attending physician? ☐ No ☐ Yes – Specify his/her name and address of his/her office: _____

_____

Date of last consultation Y M D

Reason and results _____

## SPOUSE INFORMATION *(If common-law spouse, please contact your plan administrator to confirm his/her eligibility.)*

Last name _____ First name _____

Height _____ ☐ ft/in ☐ m/cm Weight _____ ☐ lb ☐ kg Sex ☐ M ☐ F

Date of birth: Y M D Place of birth _____

Occupation _____

Telephone no. _____ Email _____

Do you have an attending physician? ☐ No ☐ Yes – Specify his/her name and address of his/her office: _____

_____

Date of last consultation Y M D

Reason and results _____

## DEPENDENT CHILDREN INFORMATION

| Last name | First name | Sex | Date of birth | Height | Weight |
|---|---|---|---|---|---|
| | | ☐ M ☐ F | Y M D | ☐ ft/in ☐ m/cm | ☐ lb ☐ kg |
| | | ☐ M ☐ F | | ☐ ft/in ☐ m/cm | ☐ lb ☐ kg |
| | | ☐ M ☐ F | | ☐ ft/in ☐ m/cm | ☐ lb ☐ kg |
| | | ☐ M ☐ F | | ☐ ft/in ☐ m/cm | ☐ lb ☐ kg |

## PLAN MEMBER CONTACT INFORMATION

Address _____

No. Street Apt.

_____ _____ Postal code

City Province

Language: ☐ English ☐ French

Plan member's name _____ Group policy no. _____ Certificate no. _____

## MEDICAL STATEMENT

Plan member: Are you actively at work and physically able to perform all work-related duties?

☐ Yes ☐ No. If not, explain _____

**IMPORTANT:** Questions 1 to 13 are intended for the plan member, the spouse and the dependent children, if applicable.
**Provide details for each affirmative answer at item 14.**

| | Member | | Spouse | | Children | |
|---|---|---|---|---|---|---|
| | Yes | No | Yes | No | Yes | No |
| 1. In the last 6 months, have you been absent from work due to illness or injury? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 2. In the last 12 months, have you used tobacco in any form whatsoever or nicotine products (gum, patches, etc.)? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 3. In the last five years: | | | | | | |
| a. have you been hospitalized in a hospital or other medical institution for observation, rest, diagnosis or treatment? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| b. have you been diagnosed with AIDS (acquired immune deficiency syndrome), ARS (AIDS-related syndrome), GLS (generalized lymphadenopathy syndrome), or any other disease involving the immunological system or been the subject of an investigation or received treatment or advice concerning said diseases? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| c. other than medication prescribed by a physician, have you used barbiturates, cocaine, heroin, marijuana, opiates or other narcotics? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| d. have you attended a treatment program for drug abuse or were you advised to do so? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| e. have you been advised to stop drinking or have you attended a treatment program for alcohol abuse? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| f. did you submit an application for life or health insurance that was declined, postponed or to which an extra premium or restriction was added, or which was issued for less than the requested amount? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| g. have you requested or received benefits, compensation or an annuity due to illness or injury? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

4. In the last five years, did you undergo or have you been advised to undergo one of the following tests? **For each test selected, specify the date, the reason and the results** at item 14 of this form.

| | Member | | Spouse | | Children | | | Member | | Spouse | | Children | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Yes | No | Yes | No | Yes | No | | Yes | No | Yes | No | Yes | No |
| a. electrocardiogram | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | e. x-ray | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| b. examination for diagnostic purposes | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | f. other tests | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| c. scan or magnetic resonance imaging | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | Specify | | | | | | |
| d. blood tests | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | | | | | | | |

5. Do you currently take medication or follow a diet?

| | | If yes, please indicate the name(s) of the medication or diet. | | | |
|---|---|---|---|---|---|
| **Member** | ☐ Yes ☐ No | | | | |
| **Spouse** | ☐ Yes ☐ No | | | | |
| **Children** | ☐ Yes ☐ No | First name | | Answer | |
| | | First name | | Answer | |

Plan member's name _____ Group policy no. _____ Certificate no. _____

6. In the past five years, have you consulted a physician or other medical practitioner, been the subject of an examination or medical follow-up, suffered or been diagnosed or treated or been advised that you are suffering from one of the following conditions or diseases?

| | Member | | Spouse | | Children | | | Member | | Spouse | | Children | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Yes | No | Yes | No | Yes | No | | Yes | No | Yes | No | Yes | No |
| a. Heart disorder or chest pains | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | o. Intestinal or kidney disorders | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| b. Blood disorders | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | p. Chronic diarrhea | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| c. Irregular pulse | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | q. Urinary disorders | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| d. Circulatory disorders | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | r. Liver disorders or gallstones | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| e. Pleurisy, asthma or emphysema | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | s. Genital disorders | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| f. Backache, neck or spinal cord disorders | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | t. Goiter or glandular disorders | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| g. Lung disorder | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | u. Neuritis | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| h. High blood pressure, elevated cholesterol or stroke | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | v. Arthritis, rheumatism, sciatica, gout, bone, joint disorder or lupus in any form | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| i. Tumours or cancer | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | w. Muscular dystrophy | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| j. Mental disorders | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | x. Diabetes | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| k. Mood disorders or other emotional disorders | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | y. Fibromyalgia or chronic fatigue syndrome | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| l. Neurological disorders, epilepsy or seizure | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | z. Any eye, ear or throat disorders | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| m. Multiple sclerosis | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | aa. Any health problems related to use of drugs and/or alcohol | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| n. Stomach disorders or ulcers | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | | | | | | | |

| | Member | | Spouse | | Children | |
|---|---|---|---|---|---|---|
| | Yes | No | Yes | No | Yes | No |
| 7. Are you aware of physical or psychological disorders or abnormalities which have not been revealed in the answers given to questions 1 to 6? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 8. Are you aware of any signs or symptoms for which a consultation and/or an examination is necessary and/or is already planned? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

9. Do you currently or do you intend to participate in any professional or hazardous sports activity, such as scuba diving, flying an aircraft, sky-diving, car racing, etc.?

| | | If yes, please specify which activity and how often. | | | |
|---|---|---|---|---|---|
| **Member** | ☐ Yes ☐ No | | | | |
| **Spouse** | ☐ Yes ☐ No | | | | |
| **Children** | ☐ Yes ☐ No | First name | | Answer | |
| | | First name | | Answer | |

10. For alcoholic beverages, tobacco and narcotics or drugs, indicate the weekly consumption. If none, indicate 0. For alcoholic beverages, 1 serving = 1 bottle of beer = 1 glass of wine = 1 ounce of alcohol.

| | | | Beer | Wine | Alcohol | Tobacco | Narcotics or drugs |
|---|---|---|---|---|---|---|---|
| **Member** | | | | | | | |
| **Spouse** | | | | | | | |
| **Legal age children** | First name | | | | | | |
| | First name | | | | | | |

Plan member's name _____ Group policy no. _____ Certificate no. _____

| **Complete questions 11 and 12 only if you are applying for the Critical Illness Benefit.** | **Member** Yes | No | **Spouse** Yes | No | **Children** Yes | No |
|---|---|---|---|---|---|---|
| 11. Have you experienced any history of optic neuritis, numbness, tingling, loss of balance, weakness of the extremities, visual disturbance or loss of sensation? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 12. Have any of your family members had heart disease, stroke, high blood pressure, cancer, diabetes, kidney disease, Huntington's Chorea, amyotrophic lateral sclerosis (ALS or Gehrig's disease), motor neuron disease, Multiple sclerosis, Alzheimer's disease, colon polyposis or any other hereditary disease? | ☐ | ☐ | ☐ | ☐ | | |

13. If you and/or your spouse answered "yes" to question 12, please complete the following table.

| | **Identify the family member** | **Illnesses (if cancer, please specify)** | **Age at the beginning of the illness** | **Age if living** | **Age at death, if applicable** |
|---|---|---|---|---|---|
| **Member** | ☐ Father ☐ Mother ☐ Brother ☐ Sister | | | | |
| | ☐ Father ☐ Mother ☐ Brother ☐ Sister | | | | |
| **Spouse** | ☐ Father ☐ Mother ☐ Brother ☐ Sister | | | | |
| | ☐ Father ☐ Mother ☐ Brother ☐ Sister | | | | |

14. Provide details for each affirmative answer given to questions 1 to 11.

| **Question no.** | **First name** | **Reason, diagnosis, treatment, medication, surgery, if applicable, results and recommendation** | **Onset of illness or date of test** Y M D | **Period during which employment or regular duties could not be performed** | **Complete recovery date** Y M D | **Names of physicians and hospitals/clinics** |
|---|---|---|---|---|---|---|
| | | | | | ☐ Yes ☐ No | |
| | | | | | ☐ Yes ☐ No | |
| | | | | | ☐ Yes ☐ No | |
| | | | | | ☐ Yes ☐ No | |
| | | | | | ☐ Yes ☐ No | |
| | | | | | ☐ Yes ☐ No | |
| | | | | | ☐ Yes ☐ No | |
| | | | | | ☐ Yes ☐ No | |
| | | | | | ☐ Yes ☐ No | |
| | | | | | ☐ Yes ☐ No | |
| | | | | | ☐ Yes ☐ No | |
| | | | | | ☐ Yes ☐ No | |
| | | | | | ☐ Yes ☐ No | |
| | | | | | ☐ Yes ☐ No | |
| | | | | | ☐ Yes ☐ No | |
| | | | | | ☐ Yes ☐ No | |

Plan member's name _____ Group policy no. _____ Certificate no. _____

## CONFIRMATION/AUTHORIZATION

**I HEREBY CONFIRM** that the statements contained in this form and in any document attached hereto or given during a phone interview are complete and true, and **I AUTHORIZE** the release of the information to Industrial Alliance Insurance and Financial Services Inc. (the Company) for the purpose of assessing my insurability under the group plan.

**I UNDERSTAND** that all the information obtained regarding this insurance application, including information on the spouse and children, form a part of the member's file and the member may consult his or her file.

**I UNDERSTAND** that the requested insurance is governed by the terms of the group insurance policy and will only take effect on the date determined by the terms of the policy once the Company approves my insurability.

**I AUTHORIZE** any healthcare provider or professional, medical organization, insurance or reinsurance company, the MIB Inc., workers' compensation board, the Policyholder, my employer, as well as any other person, public or private organization or institution holding files or information concerning myself, or if applicable, concerning my minor age children, to provide and exchange with the Company, its employees, its reinsurers or their authorized agents, any information required to assess my insurability or my minor age children's insurability, under the group plan.

**I ALSO AUTHORIZE** the Company, its employees and its reinsurers, to exchange with its subsidiaries and other insurers or financial institutions, the personal information obtained to review my insurability, or, if applicable, my minor age children's insurability, and to make inquiries so as to allow them to assess the risk.

**I ALSO AUTHORIZE** the Company to send any abnormal test results to my personal physician.

**I ALSO AUTHORIZE** the Company and its reinsurers to make a brief report of my personal health information to MIB.

This confirmation/authorization is valid for the purposes of the current group insurance policy. **A photocopy of this confirmation/authorization has the same value as the original.**

**IMPORTANT:** If you send this form by secure messaging, please complete the "electronic signature" section below. If you are not using secure messaging, please sign this form by hand and fax or mail it to us.

How do you wish to send the form? ☐ By secure messaging ☐ By fax or mail

| **Electronic signature:** | **Member** | **Spouse** | **Legal age child** | **Legal age child** |
|---|---|---|---|---|
| By checking this box, I AFFIX my electronic signature, meaning that I ACKNOWLEDGE that I have read, understood and accepted the above statements. | ☐ Confirmed | ☐ Confirmed | ☐ Confirmed<br>Child's first name<br>_____ | ☐ Confirmed<br>Child's first name<br>_____ |

**Physical signature:**

Date Y M D

Plan member's signature **X** _____

Spouse's signature **X** _____

Signature(s) of legal age child(ren) **X** _____

## WHERE TO SUBMIT THIS FORM?

**By secure messaging in your My Client Space account** – it's quick and easy!

| Here's how: | |
|---|---|
| 1. Save the form to your computer | 4. Click on *Sign In* |
| 2. Go to ia.ca/myaccount | 5. Click on the envelope at the top of the page |
| 3. Enter your access code and password | 6. Click on *New message* |
| | 7. Fill in the information and attach the form you saved previously |

**By fax:** 1-888-780-3486

**By mail:** Medical Underwriting
PO Box 790, Station B
Montreal, Quebec H3B 3K6

**THIS PAGE IS TO BE KEPT ON FILE BY THE PLAN MEMBER.**

## PRE-NOTICE FROM THE MIB INC.

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 MIB Inc., 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 coverage, or if a claim for benefits is submitted to such a company, the MIB will supply such company with the information it may have in its files upon request.

Upon receipt of a request from you, the MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of the information contained in the MIB's files, you may contact them and request a correction. The address of the MIB's information office is: MIB, 330 University Avenue, Suite 501, Toronto, Ontario M5G 1R7, telephone: 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.

## NOTICE

In order to consider your request for insurance, we may ask for additional information.

You may be contacted to provide additional information about your health and financial status. When contacted, you may be asked to complete a medical or cognitive examination and provide a blood or urine sample.

## DISCLOSURE

At Industrial Alliance Insurance and Financial Services Inc. (the Company), the personal information we collect concerning you and your dependents is kept in strict confidence and is only used for the purposes you have authorized.

Your personal file will be kept at the Company's offices.

You have the right to request access to your personal information and, if necessary, correct any inaccurate information. In order to do so, send a written request to the following: Industrial Alliance Insurance and Financial Services Inc., Information Access Officer, 1080 Grande Allée West, PO Box 1907, Station Terminus, Quebec City, Quebec G1K 7M3.

Access to your personal information will be limited to the Company's employees, agents, reinsurers and service providers in the performance of their duties, individuals to whom you have granted access, and persons authorized by law.

For the purposes of audits and administrative reporting, the Company may release to your Employer/Policyholder statistical financial information without personal identifiers.