

As plan administrator, if you use My Client Space to process the changes, please retain the form for your records. If you do not use My Client Space, submit a copy of the form to Industrial Alliance Insurance and Financial Services Inc. and retain the original. You can submit the copy of the form by:

<p>Quebec</p> <p>Fax: 1-888-780-2376</p> <p>Mail: Administration PO Box 790, Station B Montreal, Quebec H3B 3K6</p>	<p>All Other Provinces</p> <p>1-888-781-0924</p> <p>Administration 522 University Avenue, Suite 400 Toronto, Ontario M5G 1Y7</p>
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TO BE COMPLETED AND SIGNED BY THE PLAN ADMINISTRATOR (Please print in ink)

Policyholder's name _____ Group policy no. _____
(Employer/Organization)

Division no. _____ Class no. _____ Certificate no. _____

Location no. or name (if applicable) _____

Plan member's name (as shown on our records) _____

Plan administrator's signature **X** _____ Date

Y	Y	Y	Y	M	M	D	D

Plan administrator's email _____ Tel. no. _____

TO BE COMPLETED AND SIGNED BY THE PLAN MEMBER (Please print in ink)

1. BASIC INFORMATION

Last name _____ First name _____

2. CHANGE OF NAME OR ADDRESS

New last name _____ New first name _____ Sex: M F

New address _____ Postal code _____
No. Street Apt. City Province


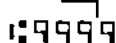
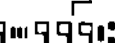

Effective date of address change (if applicable)

Y	Y	Y	Y	M	M	D	D

 Language: English French

3. DIRECT DEPOSIT OF YOUR HEALTH AND/OR DENTAL CLAIM REIMBURSEMENTS AND NOTIFICATION* OF CLAIM PROCESSING

Banking information for direct deposit:

	Transit #	Institution #	Account #																					
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	↑	↑	↑																					
																								
1	2	3	4																					

Email address for notification*: _____
 Personal Work

I do not want to receive notification

1 Cheque number (do not write this number).

2 Transit number (5 digits).

3 Financial institution number (3 digits).

4 Account number. The format may vary from one financial institution to another. Indicate **all** numbers and only the numbers.

* You will be considered as having refused the notification if you do not provide your banking information or your email address or if you check "I do not want to receive notification".

Note: You can view the status and details of your health and/or dental claims via My Client Space, our secure website, at any time.

Please complete all four pages of this form and sign the "PLAN MEMBER CONFIRMATION/AUTHORIZATION" section.

IMPORTANT: The basic dependents' life insurance coverage will be applied automatically if your plan includes this benefit and your dependents (spouse and children) are eligible. This requirement applies regardless of the coverage chosen for the health and dental benefits (individual, family, single parent, couple or refused coverage).

4. SPOUSE AND DEPENDENT CHILDREN INFORMATION

	Last name	First name	Sex	Date of birth	If age 21 ¹ or over, specify
<input type="checkbox"/> Add spouse ² <input type="checkbox"/> Delete spouse			<input type="checkbox"/> M <input type="checkbox"/> F	Y Y Y Y M M D D 	
<input type="checkbox"/> Add child <input type="checkbox"/> Delete child			<input type="checkbox"/> M <input type="checkbox"/> F	Y Y Y Y M M D D 	Full-time student <input type="checkbox"/> Yes <input type="checkbox"/> No handicapped <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Add child <input type="checkbox"/> Delete child			<input type="checkbox"/> M <input type="checkbox"/> F	Y Y Y Y M M D D 	Full-time student <input type="checkbox"/> Yes <input type="checkbox"/> No handicapped <input type="checkbox"/> Yes <input type="checkbox"/> No

¹ The age limit may vary depending on your plan. Please contact your plan administrator to confirm this information.

² If your spouse is a common-law spouse, please contact your plan administrator to confirm his/her eligibility.

Does your spouse already have health and/or dental coverage under another group plan? Yes No

If Yes, specify his/her: Health coverage: Individual Family Single parent Couple

Effective date: Y Y Y Y M M D D
| | | | | | | |

Dental coverage: Individual Family Single parent Couple

Effective date: Y Y Y Y M M D D
| | | | | | | |

Insurer's name _____

Group policy no. _____ Certificate no. _____

If any of your dependent children have coverage under a group insurance plan other than yours or your spouse's, complete the following table:

Child Last name, First name	Plan type (e.g. school plan, etc.)	Insurer name	Group policy no.

5. CHANGE OF COVERAGE (Evidence of insurability may be required, depending on the nature of the change.)

I want to change my coverage* to: Individual Family Single parent¹ Couple¹

¹ Select this coverage only if offered by your plan. Please be advised that if the single parent and couple categories are not offered, you will automatically have family coverage.

I want to change my plan/option/module to (if applicable): _____

- Reason:**
- Marriage/Civil Union – Date Y Y Y Y M M D D
| | | | | | | |
 - Common-law spouse – Cohabitation began on Y Y Y Y M M D D
| | | | | | | |
 - Divorce/Separation – Date Y Y Y Y M M D D
| | | | | | | |
 - Birth/Adoption – Date Y Y Y Y M M D D
| | | | | | | |
 - New coverage under spouse's plan –
Began on Y Y Y Y M M D D
| | | | | | | |
 - Termination of coverage under spouse's plan –
Terminated on Y Y Y Y M M D D
| | | | | | | |
 - Other _____ – Date Y Y Y Y M M D D
| | | | | | | |

*If you and/or your dependents **already have health and/or dental coverage under another group plan**, you can refuse health and/or dental coverage under this group plan by checking the following boxes:

- For myself and my dependents:** I refuse health benefits I refuse dental benefits
- For my dependents only:** I refuse health benefits I refuse dental benefits

Note: If you refuse coverage and wish to request it at a later date, certain conditions may apply. Please contact your plan administrator for further details.

6. OPTIONAL BENEFITS

If Extensia optional benefits (life, accidental death & dismemberment [AD&D] and critical illness insurance) are offered as part of your group plan and you would like to add, change or remove this coverage, simply go to My Client Space, our secure website, and under *Extensia – Optional Benefits*, click on *Forms* and then on *Extensia Application, change or termination* form. Please complete and submit the form to our offices. Do not complete the table below.

If Extensia benefits are not offered as part of your plan, please check with your plan administrator if standard optional benefits are offered as part of your group plan and if you should complete the *Evidence of Insurability* form (F54-002A). Complete the table below to add or remove coverage.

Standard optional benefits:

	Life	Accidental Death and Dismemberment	Critical Illness	Statement (complete only if you want to add optional life and/or critical illness coverage OR you want to change to non-smoker status)
Plan member	<input type="checkbox"/> Terminate coverage <input type="checkbox"/> Add coverage*: \$ _____	<input type="checkbox"/> Terminate coverage <input type="checkbox"/> Add coverage*: \$ _____	<input type="checkbox"/> Terminate coverage <input type="checkbox"/> Add coverage*: \$ _____	In the last 12 months, have you used tobacco in any form whatsoever, nicotine products (gum, patches, etc.) or marijuana? <input type="checkbox"/> Yes <input type="checkbox"/> No
Spouse	<input type="checkbox"/> Terminate coverage <input type="checkbox"/> Add coverage*: \$ _____	<input type="checkbox"/> Terminate coverage <input type="checkbox"/> Add coverage*: \$ _____	<input type="checkbox"/> Terminate coverage <input type="checkbox"/> Add coverage*: \$ _____	In the last 12 months, has your spouse used tobacco in any form whatsoever, nicotine products (gum, patches, etc.) or marijuana? <input type="checkbox"/> Yes <input type="checkbox"/> No
Children	<input type="checkbox"/> Terminate coverage <input type="checkbox"/> Add coverage*: \$ _____	<input type="checkbox"/> Terminate coverage <input type="checkbox"/> Add coverage*: \$ _____	<input type="checkbox"/> Terminate coverage <input type="checkbox"/> Add coverage*: \$ _____	Each child will benefit from the coverage amount you added.

*Please indicate the coverage amount to be added. Do not include basic coverage or optional coverage currently in place.

7. APPOINTMENT OR CHANGE OF BENEFICIARY (If you do not appoint a beneficiary, the benefit will be payable to the estate.)

This beneficiary designation revokes any previous one(s).

1. Primary beneficiaries

If you name multiple primary beneficiaries, the total allocation must be equal to or less than 100%. If less than 100%, the difference will be payable to the estate. Please do not indicate dollar amounts.

If the previously designated beneficiary was irrevocable, complete the following table as well as the "Irrevocable beneficiary" section.

Last name	First name	Relationship	Date of birth	%
			Y Y Y Y M M D D 	
			Y Y Y Y M M D D 	
			Y Y Y Y M M D D 	

2. Contingent beneficiaries

If you wish, you can also appoint contingent beneficiaries in the event all primary beneficiaries predecease you. If you name multiple contingent beneficiaries, the total allocation must be equal to or less than 100%. If less than 100%, the difference will be payable to the estate. Please do not indicate dollar amounts.

Last name	First name	Relationship	Date of birth	%
			Y Y Y Y M M D D 	
			Y Y Y Y M M D D 	

IMPORTANT: For Quebec residents only – to be completed if you appointed your spouse (marriage or civil union) as a beneficiary.

In Quebec, the designation of a spouse, excluding a common-law spouse, as a beneficiary is irrevocable* unless you check the following box:

Revocable beneficiary

*To change the appointment of an irrevocable beneficiary, his/her written consent will be required.

Please sign the "PLAN MEMBER CONFIRMATION/AUTHORIZATION" section on the next page.

8. IRREVOCABLE BENEFICIARY (If applicable)

If you have appointed an irrevocable beneficiary, his/her written consent is required in order to change the designation. In that case, please have the irrevocable beneficiary sign below. Please note that the beneficiary must have attained the age of majority to provide his/her consent.

Irrevocable beneficiary's signature **X** _____ Date

Y	Y	Y	Y	M	M	D	D

9. TRUSTEE DESIGNATION (Not applicable in Quebec*)

You can appoint a trustee to receive any amount due to any beneficiary under the age of majority.

Trustee's last name _____ First name _____

* In Quebec, there may be issues with respect to the appointment of a trustee. You should consult a legal advisor before appointing a trustee.

PLAN MEMBER CONFIRMATION/AUTHORIZATION

I HEREBY CONFIRM that the information contained in this form is true and complete to the best of my knowledge.

If providing or changing information on my spouse and/or dependent children, **I CONFIRM** that I am authorized to disclose information concerning them for the purpose of determining their eligibility for coverage under my Employer's/Policyholder's group insurance plan.

On behalf of myself and my dependents, **I CONSENT TO THE RELEASE** of the information contained in this form to my Employer/Policyholder and Industrial Alliance Insurance and Financial Services Inc. ("iA Financial Group"), its employees, agents, reinsurers and service providers for the purposes of underwriting, administration, claims processing and determining coverage for myself and my dependents in my Employer's/Policyholder's group insurance plan. In addition, **I UNDERSTAND** that personal information may be subject to disclosure to those authorized under the applicable laws within or outside of Canada.

If my Social Insurance Number is used as my certificate number, **I AUTHORIZE** its use for the administration of my group insurance plan.

If I enrol in direct deposit, **I AUTHORIZE** iA Financial Group to deposit in my bank account, using the banking information I have provided in section 3, any amounts payable in regards to a claim that I submit under my group insurance plan. **I AGREE** that this authorization will apply until such time as I submit a written request to the contrary to iA Financial Group. **I UNDERSTAND** that iA Financial Group will have no further obligation with regard to the claims paid. **I ALSO UNDERSTAND** that iA Financial Group can, without prior notice, terminate the direct deposit of my claims payments. This authorization takes effect on the date indicated below and will be valid for all other active bank accounts at this or any other financial institution that I may name in the future.

Furthermore, if I enrol in direct deposit, **I UNDERSTAND** and **AGREE** that if I provide iA Financial Group with incorrect banking information or if I fail to notify iA Financial Group of any change in my banking information and, as a result of this error or omission, the amount of a paid claim is deposited into the wrong bank account, iA Financial Group cannot be held responsible or liable for this error or omission or be obligated to reimburse me if iA Financial Group is unable to recover the amount that was paid into the wrong account.

I AGREE that a photocopy of this Confirmation/Authorization shall be as valid as the original.

Plan member's signature **X** _____ Date

Y	Y	Y	Y	M	M	D	D

DISCLOSURE

At Industrial Alliance Insurance and Financial Services Inc. ("iA Financial Group"), 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 iA Financial Group's offices.

You have the right to request access to your personal information and, if necessary, correct any inaccurate information. To do so, send a written request to: 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 employees, agents, reinsurers and service providers of iA Financial Group 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, iA Financial Group may release to your Employer/Policyholder statistical financial information without personal identifiers.