www.inalco.com

INDUSTRIAL ALLIANCE
INSURANCE AND FINANCIAL SERVICES INC.

Quebec
Group Administration
P.O. Box 790, Station B
Montreal, Quebec H3B 3K6

Ontario, Atlantic and Western Provinces
Group Administration
522 University Ave, Suite 400
Toronto, Ontario M5G 1Y7

Individual Health Insurance Application TRANSIT

To convert a group life insurance, please complete the Request for conversion form (F54-030A).

Please print in ink and sign.

1. APPLICANT (PERSON TO BE INSURED)

Last name _____ First name _____ Date of birth Y M D

Address _____
No. Street Apt.

_____ Postal code
City Province

Correspondence: ❑ English ❑ French Sex: ❑ Male ❑ Female Home phone no. Email _____

2. REASON FOR APPLYING

❑ CONVERSION
of my group insurance coverage into individual health insurance (Please complete section 3.)

❑ CHANGE
to my individual insurance policy (Please complete section 4.)

3. CONVERSION

Group Insurance Policy no. Certificate no.

Event leading to application for conversion: _____ Employment termination date Y M D

Coverage requested: Medical: ❑ INDIVIDUAL
❑ FAMILY (Complete section 5).
Drug coverage is not offered to Quebec residents, except in case of out of province emergency.

Dental (optional): ❑ INDIVIDUAL
❑ FAMILY (Complete section 5).
This option is only offered to participants who want to convert from a group insurance plan that includes dental coverage.

4. CHANGE

Contract no. 4 0 0 -

❑ I would like to add family coverage. (Complete section 5. If you want to add family coverage at a later date, doing so will depend on the provisions of your individual policy.)

❑ I would like to add one or more dependents. (Complete section 5.)

❑ I would like to terminate coverage for all my dependents as of Y M D

❑ I would like to terminate coverage for _____ as of Y M D
Name

5. DEPENDENTS

Last name	First name	Sex	Date of birth	
Spouse		❑ M ❑ F	Y M D	❑ Married/Civil union ❑ Common-law: living together since Y M D
Child		❑ M ❑ F		If age 21 or over, specify: ❑ Full-time student ❑ Disabled
Child		❑ M ❑ F		If age 21 or over, specify: ❑ Full-time student ❑ Disabled

APPLICANT CONFIRMATION/AUTHORIZATION

I HEREBY APPLY for the individual benefits with Industrial Alliance for which I am eligible and **CONFIRM** that the information contained in this form is true and complete to the best of my knowledge.

If applying for benefits for my dependents, **I CONFIRM THAT I AM AUTHORIZED** to disclose information concerning them for the purposes of determining their eligibility for coverage.

On behalf of myself and my dependents, **I CONSENT TO THE RELEASE** of the information contained in this form to Industrial Alliance, its employees, agents, reinsurers and service providers for the purpose of underwriting, administration, claims processing and the enrolment of myself and my dependents under an individual insurance plan with Industrial Alliance.

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

Applicant's signature _____ Date Y M D

FOR INSURER ONLY

	Processed on *by*

YOU MUST COMPLETE AND SIGN THE SECTIONS ON THE REVERSE SIDE.

6. PREMIUM PAYMENT BY PRE-AUTHORIZED WITHDRAWALS

Name of Financial Institution: _____

Name of Account Owner(s): _____ and _____

Banking Information:

Please attach a cheque specimen marked VOID.
(Please attach here.)

I authorize Industrial Alliance Insurance and Financial Services Inc. and the financial institution designated (or any other financial institution I may authorize at any time) to begin deductions as per my instructions for regular recurring payments and/or one-time payments from time to time, for payment of all premiums, deposits, instalments and charges arising from the contract hereunder mentioned.

I authorize the direct withdrawal of premiums from my bank account, whose particulars appear above or on the enclosed cheque, until such time as I make a written request to the contrary. This authorization, which takes effect on the signature date below, is valid for all other active bank accounts in this or any other financial institution that I may name in the future.

I authorize the direct withdrawal of premiums on the first day of each month.

I waive the right to receive pre-notification of an increase or decrease in the amount to be debited or a change in the date and/or frequency of these payments.

I agree that Industrial Alliance is not required to provide me with a written notice of a change in the pre-authorized withdrawals (PAW) amount that is made as a result of my request. If a PAW is dishonoured for any reason such as, but not limited to, insufficient funds ("NSF"), stop payment or account closed, Industrial Alliance is authorized to resubmit the payment. **Any charges incurred by Industrial Alliance as a result of the dishonoured PAW will be added to the subsequent PAW.**

I may cancel or modify this PAW agreement at any time, subject to providing Industrial Alliance with thirty (30) days notice in writing. To obtain a cancellation form or for more information on my right to cancel the PAW agreement, I may contact my financial institution or visit www.cdnpay.ca regarding Rule H1: Pre-authorized debits (PADs). Any cancellation of this PAW agreement will not affect my insurance contract(s) and/or contract(s) for financial services, so long as payment is provided by an alternate method.

Industrial Alliance may not assign this PAW agreement without providing, any time prior to the next PAW, written notice to me of the assignment.

I have certain recourse rights if any PAW does not comply with this PAW agreement. For example, I have the right to receive reimbursement for any PAW that is not authorized or is not consistent with this PAW agreement. To obtain more information on my recourse rights, I should contact my financial institution or visit www.cdnpay.ca.

X _____ Y M D _____

Signature of Account Owner — Date

X _____ Y M D _____

Signature of Account Owner (if applicable) — Date

7. DIRECT DEPOSIT REQUEST FOR HEALTH AND DENTAL BENEFITS

❑ Yes, I am subscribing to **direct deposit** to have my health and dental claim reimbursements automatically deposited in my bank account, and to be informed by email when claims have been processed.

Banking information: ❑ Same as pre-authorized withdrawals. If not, specify:

_____ _____ _____ Email: _____ ❑ Home ❑ Work

Branch no. (5 digits) — Financial Institution No. (3 digits) — Bank Account No.

DISCLOSURE

At Industrial Alliance, 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 Industrial Alliance'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 Industrial Alliance's employees, agents, reinsurers and service providers in the performance of their jobs, individuals to whom you have granted access, and persons authorized by law.