

For Office Use Only

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 / y y y y) Province, State or Country

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

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

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 / y y y y) Province, State or Country

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

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

Note: If Spouse is also 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

DO NOT INCLUDE ANY BENEFITS CURRENTLY IN FORCE

Member Term Life Insurance

Amount desired:
 \$ _____
Units of \$35,000, maximum \$805,000

Member Critical Illness Insurance

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

Accidental Death & Dismemberment Insurance

Available only if the Member is insured for Member Term Life Insurance and/or Critical Illness Insurance
 \$ _____ Member Only Plan
Units of \$35,000, maximum \$805,000 Member and Family Plan

Office Overhead Insurance

Amount desired:
 \$ _____ Waiting Period:
 30 Days 90 days
Units of \$100 (minimum \$500) to a maximum of 50 units or \$5,000 per month

Spouse Term Life Insurance

Amount desired:
 \$ _____
Units of \$35,000, maximum \$805,000

Spouse 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
 \$ _____
Units of \$5,000, maximum \$20,000

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**) _____

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 Office Overhead Insurance. If applying for Accidental Death & Dismemberment Insurance you need only complete questions 2 to 6. If applying for Dependent Children Term Life Insurance, please complete question 22.

Member: Height _____ Weight _____ Spouse: Height _____ Weight _____	Member		Spouse		Please provide details of 'Yes' answers including dates, duration and names and addresses of all doctors, hospitals, etc. If you require more space, please attach a separate sheet of paper, signed and dated.		
	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 12 months ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<table border="1"> <thead> <tr> <th>Member Details</th> <th>Spouse Details</th> </tr> </thead> </table>	Member Details	Spouse Details
Member Details	Spouse Details						
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? 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? 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? 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 (other than routine checkup or minor injury) 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"/>			
22. Children's Coverage: (complete when applying for Dependent Children Term Life Insurance) Please specify number of eligible children to be insured: _____ a) Are all children to be insured in good health and free from symptoms of illness and disease? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No", please give details specifying child's name and date of birth. b) Do any of your eligible dependent children intend to travel or reside outside Canada or the United States for more than a month? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please provide details.					Details:		

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

Spouse Signature (when applying for insurance) _____ Date _____

Member Name (**please print**) _____

Spouse Name (please print) _____

Please 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 <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
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	/	M		M		M	/	Y		Y		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) _____

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).
- 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 1ST 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 (page 5) 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 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 _____

Spouse Signature (when applying for insurance) _____ Date _____

Member Name (**please print**) _____

Spouse Name (please print) _____

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 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

Notice to Applicant – Please Read Carefully

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.



™ Trademark of Industrial Alliance Insurance and Financial Services Inc., used under license by Industrial Alliance Pacific Insurance and Financial Services Inc.

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
E-mail: group@iapacific.com