

Supplemental Health Questionnaire



You are being asked to complete this Questionnaire because the amount of insurance which you have applied for exceeds the amounts indicated on your Insurance Application and requires that Industrial Alliance Pacific Insurance and Financial Services Inc. ("IAP") consider additional health information. If you answer 'YES' to any of the Health Questions or the sum of your Insured Financed Amount plus Insured Residual Value for Life or CI exceeds \$250,000, this Application will be underwritten.

Is the Insurance Application attached? Y N

If 'No', give date Insurance Application was completed:

DD	MMM	YYYY
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Tell us About Yourself. (Please Print)

APPLICANT 1 / DEBTOR - SURNAME		FIRST NAME(S)		APPLICANT 2 / CO-DEBTOR - SURNAME		FIRST NAME(S)	
SEX <input type="checkbox"/> M <input type="checkbox"/> F	SMOKER <input type="checkbox"/> Y <input type="checkbox"/> N	HEIGHT _____ <input type="checkbox"/> in <input type="checkbox"/> cm	WEIGHT _____ <input type="checkbox"/> lbs <input type="checkbox"/> kg	SEX <input type="checkbox"/> M <input type="checkbox"/> F	SMOKER <input type="checkbox"/> Y <input type="checkbox"/> N	HEIGHT _____ <input type="checkbox"/> in <input type="checkbox"/> cm	WEIGHT _____ <input type="checkbox"/> lbs <input type="checkbox"/> kg
DATE OF BIRTH D D M M M Y Y Y Y		PLACE OF BIRTH (PROVINCE, STATE OR COUNTRY)		DATE OF BIRTH D D M M M Y Y Y Y		PLACE OF BIRTH (PROVINCE, STATE OR COUNTRY)	
OCCUPATION		TELEPHONE NUMBER ()		OCCUPATION		TELEPHONE NUMBER ()	
APPLICATION NO. / CERTIFICATE		H.O. USE ONLY		APPLICATION NO. / CERTIFICATE		H.O. USE ONLY	
NAME AND ADDRESS OF PERSONAL PHYSICIAN				NAME AND ADDRESS OF PERSONAL PHYSICIAN			
DATE AND REASON LAST CONSULTED ANY DOCTOR				DATE AND REASON LAST CONSULTED ANY DOCTOR			
DIAGNOSIS, TREATMENT AND/OR MEDICATION PRESCRIBED				DIAGNOSIS, TREATMENT AND/OR MEDICATION PRESCRIBED			

HEALTH QUESTIONS	Applicant 1 Debtor		Applicant 2 Co-Debtor		Particulars of 'Yes' Answers with dates, duration, type of disease, disorder or injury and names and addresses of all doctors, hospitals, etc.
	YES	NO	YES	NO	
For Life, Critical Illness and/or Disability Insurance:					
1. Have you ever attended a medical facility, consulted a physician, been diagnosed with, taken prescribed medication or been treated for:					If you require more space, please attach a separate sheet of paper, signed and dated.
<ul style="list-style-type: none"> Coronary artery disease, chest pain, heart attack, murmur or other condition related to the heart or circulatory system, high blood pressure, diabetes, blood disorder, stroke or transient ischemic attack (TIA), cancer or tumour, a positive HIV test or any other auto-immune disorder including AIDS, hepatitis or other liver disorder, abnormal electrocardiogram (ECG), abnormal mammogram or PAP smear, disease or disorder of the breast, prostate or bladder. 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
2. Within the past 24 months have you attended a medical facility, consulted a physician, been diagnosed with, taken prescribed medication or been treated for:					
<ul style="list-style-type: none"> Shortness of breath, asthma, emphysema or other lung or respiratory disorders, systemic lupus, rheumatoid arthritis, disorder of the reproductive organs, kidney disease, ulcerative colitis, Crohns' disease or other disorders of the stomach or pancreas, seizures, paralysis, Multiple Sclerosis or other disorders of the nervous system, stress, anxiety, depression or any other mental or psychiatric disorder, alcohol or drug abuse. 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
3. Have you ever applied for any insurance which was declined, modified or rated?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
For Critical Illness Insurance Only:					
4. Have any of your natural parents, brothers or sisters ever suffered from any of the following conditions: heart disease, stroke, high blood pressure, diabetes, cancer or tumor, systemic lupus, multiple sclerosis, motor neurone disease including Amyotrophic Lateral Sclerosis (ALS), polycystic kidney disease or any inherited disease? Please provide the relationship of the family member (mother, father, sister, brother), and the nature of the disease including their age when diagnosed.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
For Disability Insurance Only:					
5. Within the past 24 months have you:					
a) Been partially or totally disabled and/or received disability or Worker's Compensation benefits;	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
b) Consulted a physician or other health care professional, been diagnosed with, taken prescribed medication or been treated for: fibromyalgia, fibrositis, osteoarthritis, chronic fatigue syndrome, strains or other disorders of the back, neck, shoulder, elbows, knees, hips or other joints, muscles, ligaments or tendons.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Here's the Fine Print. Please give us Your Authorization. (Please Read, Sign and Date)

I acknowledge receipt of the Disclosure Notice describing the operation of the Medical Information Bureau. I authorize:

- any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau, 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 their reinsurers any such information. A copy of this authorization shall be as valid as the original.
- 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.
- IAP to release any abnormal test results to my personal physician.

I understand that full coverage will not be in effect until my Application, this Questionnaire and any other medical information required is approved by IAP. I confirm that the foregoing answers, forming part of an Application for group insurance to IAP, are true, complete and correctly recorded. 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 Insurance. I acknowledge that it is my responsibility to notify IAP of any change in my health or insurability.

APPLICANT 1 - DEBTOR

DATE

APPLICANT 2 - CO-DEBTOR

DATE

FORM 7194 (FEB/2008)

↓ Detach Here ↓

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Disclosure Notice - Medical Information Bureau

Please Read Carefully and Keep With Your Records
Information regarding your insurability will be treated as confidential. Industrial Alliance Pacific Insurance and Financial Services Inc. ("IAP") or its reinsurers may, however, make a brief report 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 a member company, the Bureau, upon request, will supply that company with the information in its file.

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 330 University Avenue, Suite 102, Toronto, Ontario, Canada M5G 1R7, telephone number (416) 597-0590.

IAP or its reinsurers may also release information in the file to other life insurance companies to whom you apply for life or health insurance, or to whom a claim for benefits is submitted.

Request for Further Information

As part of our procedure to assess your eligibility for insurance you may receive a telephone call from a member of our staff. This interview, if required, will be of short duration and will take place at a time convenient to you. If you are not available when we call, we will try and arrange that you return our call at no expense to you.

This information will be held in strictest confidence. Inquiries concerning this notice should be directed to the Underwriting Department of IAP.

Underwritten by:

Industrial Alliance Pacific Insurance and Financial Services Inc., 2165 Broadway W, P.O. Box 5900, Vancouver, BC, V6B 5H6, (604) 737-9374, 1-800-665-4458