Supplemental Health Questionnaire

You are being asked to complete this Questionnaire because either a question on the Group Insurance Application was answered 'YES', or the amount of insurance which you have applied for requires additional information for further consideration of your Application. If required, this Application may be underwritten by Industrial-Alliance *Pacific* Life Insurance Company ("Industrial Alliance Pacific").

Is the Insurance Application attached? ❑ Y ❑ N

If 'No', give date Insurance Application was completed: DD | MMM | YYYY

Tell us about yourself (please print)

APPLICANT 1 – SURNAME	FIRST NAME(S)	APPLICANT 2 – SURNAME	FIRST NAME(S)
SEX ❑ M ❑ F / SMOKER ❑ Y ❑ N	HEIGHT ______ ❑ in ❑ cm / WEIGHT ______ ❑ lbs ❑ kg	SEX ❑ M ❑ F / SMOKER ❑ Y ❑ N	HEIGHT ______ ❑ in ❑ cm / WEIGHT ______ ❑ lbs ❑ 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.	H.O. USE ONLY	APPLICATION NO.	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	

HAVE YOU EVER HAD, BEEN TOLD YOU HAVE, BEEN TREATED, TESTED OR COUNSELLED FOR:	Applicant 1 YES	Applicant 1 NO	Applicant 2 YES	Applicant 2 NO	Particulars of 'Yes' Answers *with dates, duration, type of disease, disorder or injury and names and addresses of all doctors, hospitals, etc.*
1. *Chest pain, palpitations, high blood pressure, heart murmur, heart attack, aneurysm, stroke, embolism, phlebitis or any other disease or disorder of the heart or blood vessels?*	❑	❑	❑	❑	
2. *Shortness of breath, persistent hoarseness or cough, spitting of blood, asthma, bronchitis, emphysema, pleurisy, tuberculosis or any other disease or disorder of the lungs or respiratory tract?*	❑	❑	❑	❑	
3. *Dizziness, fainting spells, convulsions, epilepsy, paralysis, numbness, multiple sclerosis, a neurological disorder or disease, persistent headaches, stress, anxiety, depression or any other mental illness?*	❑	❑	❑	❑	
4. *Cancer, tumor, cyst, growth or abnormal mole?*	❑	❑	❑	❑	
5. *Ulcerative colitis, Crohns' disease, ulcer or any other disease or disorder of the stomach, intestines or gall bladder?*	❑	❑	❑	❑	
6. *Jaundice, hepatitis, hepatitis carrier state, cirrhosis or any other disease or disorder of the liver?*	❑	❑	❑	❑	
7. *Kidney disease or disorder, venereal or any other sexually transmitted disease?*	❑	❑	❑	❑	
8. *Diabetes, goiter, disorder of the thyroid, pancreatitis or other endocrine disorder?*	❑	❑	❑	❑	

If you require more space, please attach a separate sheet of paper, signed and dated.

FORM 7397 (MAY/2007)

Please turn over and complete reverse side ➥

⬇ ***Detach Here*** ⬇

Supplemental Health Questionnaire

Underwritten by:

Industrial-Alliance *Pacific* Life Insurance Company
2165 Broadway W, P.O. Box 5900
Vancouver, BC V6B 5H6
(604) 737-9374
1-800-923-5626

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

HAVE YOU EVER HAD, BEEN TOLD YOU HAVE, BEEN TREATED, TESTED OR COUNSELLED FOR:	Applicant 1 YES	Applicant 1 NO	Applicant 2 YES	Applicant 2 NO	Particulars of 'Yes' Answers *with dates, duration, type of disease, disorder or injury and names and addresses of all doctors, hospitals, etc.*
9. *Frequent or difficult urination, protein, sugar, blood or pus in urine or any other disorder of the bladder, prostate or reproductive organs?*	☐	☐	☐	☐	
10. *Anemia or any other disease or disorder of the blood?*	☐	☐	☐	☐	
11. *Any disease or disorder of the skin, muscles, spine, bones or joints including pain in the back or neck, arthritis or deformity?*	☐	☐	☐	☐	
12. *Acquired Immune Deficiency Syndrome (AIDS), Aids Related Complex (ARC), Human Immune Deficiency Virus (HIV), enlargement of lymph nodes, chronic diarrhea, unexplained infections, weight loss or any other immunological disorder?*	☐	☐	☐	☐	
13. *Any disease, disorder, ailment or injury not already mentioned?*	☐	☐	☐	☐	
14. *Females only. Any disease, disorder or surgery on breast, ovary or uterus? If pregnant, please provide due date.*	☐	☐	☐	☐	
15. *Have you been treated for or advised to seek treatment for drug and/or alcohol usage?*	☐	☐	☐	☐	
16. *Have you been a patient in a hospital or other medical facility?*	☐	☐	☐	☐	
17. *Are you currently under observation, having any special examinations or tests, have pending surgery or taking prescribed medication?*	☐	☐	☐	☐	
18. *In the last 10 years have you used drugs that were not prescribed by your doctor? (Includes marijuana, LSD, cocaine, heroin, barbiturates or other narcotics.)*	☐	☐	☐	☐	
19. *Has any immediate family member [father, mother, brother(s), sister(s)] been diagnosed or suffered from diabetes, heart disease, cancer, polycystic kidney disease, Huntington's chorea, or any other genetic disease or disorder?*	☐	☐	☐	☐	

Please read, sign and date:

HERE'S THE FINE PRINT. PLEASE GIVE US YOUR AUTHORIZATION.

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

i) *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 Life Insurance Company ("Industrial Alliance Pacific") or their reinsurers any such information. A copy of this authorization shall be as valid as the original.*

ii) *Industrial Alliance Pacific 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.*

iii) *Industrial Alliance Pacific to release any abnormal test results to my personal physician.*

I understand that no coverage will be in effect until my Application, this Questionnaire and any other medical information required is approved by Industrial Alliance Pacific. I confirm that the foregoing answers, forming part of an application for group insurance to Industrial Alliance Pacific, 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 coverage. I acknowledge that it is my responsibility to notify Industrial Alliance Pacific of any change in my health or insurability.

X		X	
APPLICANT 1	DATE	APPLICANT 2	DATE

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 Life Insurance Company ("Industrial Alliance Pacific") 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.

Industrial Alliance Pacific 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 Industrial Alliance Pacific.

Money Back Guarantee

You have thirty days after you receive your Certificate to decide if it meets your needs. If it does not, return it to our Head Office or to the Financial Institution from whom you bought it. We will cancel your coverage from the Effective Date of Insurance and will refund any premiums paid by you.