iA Financial Group ia.ca

Evidence of insurability

GROUP INSURANCE

General information *(Please print in ink)*

Policyholder's name (Employer/organization) _____

Group policy no. _____ Division no. _____ Class no._____ Certificate no. _____

Member's last name _____ First name _____

Employment date Y M D Eligibility date Y M D Annual salary $_____

1. Reason for completing this form

☐ Applying for optional benefits

☐ Applying for an additional amount of insurance which exceeds the maximum amount specified by the plan:

☐ Basic life ☐ Disability Income ☐ Critical Illness

☐ Plan member late enrolment in group insurance plan

☐ Dependents late enrolment in group insurance plan. If the spouse (and the children, if any) is or was covered under another group insurance plan, please specify the following:

Insurer's name _____ Group policy no. _____ Certificate no. _____

Date and reason of the coverage termination, if any _____

☐ Other, specify _____

2. Coverage requested for the benefit(s) listed below

Please refer to the group insurance booklet or the plan administrator to confirm coverage amounts.

Benefits	Current Insurance Amount	Additional Insurance Amount Requested	Total
Critical Illness			
1. Member	$	$	$
2. Spouse	$	$	$
3. Children[1]	$	$	$
Basic Life			
1. Member	$	$	$
2. Spouse	$	$	$
3. Children[1]	$	$	$
Optional Life			
1. Member	$	$	$
2. Spouse	$	$	$
3. Children[1]	$	$	$
Short-term disability	$	$	$
Long-term disability	$	$	$
Medical	☐ Individual ☐ Family ☐ Single parent ☐ Couple		
Dental	☐ Individual ☐ Family ☐ Single parent ☐ Couple		

[1] Each child will benefit from the insurance amount you selected.

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Validate and Print

Plan member's name _____ Group policy no. _____ Certificate no. _____

The following pages must be completed and signed by the plan member and the dependents, if applicable. ***(Please print in ink.)***

Please check below to open each section which pertains to the proposed insureds.

Important: Please provide the information requested for the proposed insureds only.

☐ PLAN MEMBER INFORMATION

Height _____ ☐ ft/in ☐ m/cm Weight _____ ☐ lb ☐ kg Sex ☐ M ☐ F

Date of birth: Y M D Place of birth _____

Occupation _____

Telephone no. _____ Email _____

Name and address of attending physician, if applicable _____

_____

Date of last consultation Y M D

Reason and results _____

☐ SPOUSE INFORMATION *(if common-law spouse, please contact your plan administrator to confirm his/her eligibility.)*

Last name _____ First name _____

Height _____ ☐ ft/in ☐ m/cm Weight _____ ☐ lb ☐ kg Sex ☐ M ☐ F

Date of birth: Y M D Place of birth _____

Occupation _____

Telephone no. _____ Email _____

Name and address of attending physician, if applicable _____

_____

Date of last consultation Y M D

Reason and results _____

☐ DEPENDENT CHILDREN INFORMATION *(If more space is required, please use another sheet. Date and sign any attached document.)*

Last name	First name	Sex	Date of birth	Height	Weight
		☐ M ☐ F	Y M D	☐ ft/in ☐ m/cm	☐ lb ☐ kg
		☐ M ☐ F		☐ ft/in ☐ m/cm	☐ lb ☐ kg
		☐ M ☐ F		☐ ft/in ☐ m/cm	☐ lb ☐ kg
		☐ M ☐ F		☐ ft/in ☐ m/cm	☐ lb ☐ kg

PLAN MEMBER CONTACT INFORMATION

Address _____

No. Street Apt.

_____ _____ Postal code

City Province

Language: ☐ English ☐ French

Validate and Print

Plan member's name _____ Group policy no. _____ Certificate no. _____

Please complete page 2 first!

MEDICAL STATEMENT

Plan member: Are you actively at work and physically able to perform all work-related duties?

☐ Yes ☐ No. If not, explain _____

IMPORTANT: Questions 1 to 13 are intended for the plan member, the spouse and the dependent children, if applicable.
Provide details for each affirmative answer at item 14.

	Member		Spouse		Children	
	Yes	No	Yes	No	Yes	No
1. In the last 6 months, have you been absent from work due to illness or injury?	☐	☐	☐	☐	☐	☐
2. In the last 12 months, have you used tobacco in any form whatsoever or nicotine products (gum, patches, etc.)?	☐	☐	☐	☐	☐	☐
3. In the last five years:						
a. have you been hospitalized in a hospital or other medical institution for observation, rest, diagnosis or treatment?	☐	☐	☐	☐	☐	☐
b. have you been diagnosed with AIDS (acquired immune deficiency syndrome), ARS (AIDS-related syndrome), GLS (generalized lymphadenopathy syndrome), or any other disease involving the immunological system or been the subject of an investigation or received treatment or advice concerning said diseases?	☐	☐	☐	☐	☐	☐
c. other than medication prescribed by a physician, have you used barbiturates, cocaine, heroin, marijuana, opiates or other narcotics?	☐	☐	☐	☐	☐	☐
d. have you attended a treatment program for drug abuse or were you advised to do so?	☐	☐	☐	☐	☐	☐
e. have you been advised to stop drinking or have you attended a treatment program for alcohol abuse?	☐	☐	☐	☐	☐	☐
f. did you submit an application for life or health insurance that was declined, postponed or to which an extra premium or restriction was added, or which was issued for less than the requested amount?	☐	☐	☐	☐	☐	☐
g. have you requested or received benefits, compensation or an annuity due to illness or injury?	☐	☐	☐	☐	☐	☐

4. In the last five years, did you undergo or have you been advised to undergo one of the following tests? **For each test selected, specify the date, the reason and the results** at item 14 of this form (or attach the document providing this information).

	Member		Spouse		Children			Member		Spouse		Children	
	Yes	No	Yes	No	Yes	No		Yes	No	Yes	No	Yes	No
a. electrocardiogram	☐	☐	☐	☐	☐	☐	e. x-ray	☐	☐	☐	☐	☐	☐
b. examination for diagnostic purposes	☐	☐	☐	☐	☐	☐	f. other tests	☐	☐	☐	☐	☐	☐
c. scan or magnetic resonance imaging	☐	☐	☐	☐	☐	☐	Specify						
d. blood tests	☐	☐	☐	☐	☐	☐							

5. Do you currently take medication or follow a diet? (Use another sheet if needed. Date and sign any attached document.)

		If yes, please indicate the name(s) of the medication or diet.			
Member	☐ Yes ☐ No				
Spouse	☐ Yes ☐ No				
Children	☐ Yes ☐ No	Child's first name		Answer	
		Child's first name		Answer	
		Child's first name		Answer	
		Child's first name		Answer	

Validate and Print

Plan member's name _____ Group policy no. _____ Certificate no. _____

6. In the past five years, have you consulted a physician or other medical practitioner, been the subject of an examination or medical follow-up, suffered or been diagnosed or treated or been advised that you are suffering from one of the following conditions or diseases?

	Member		Spouse		Children			Member		Spouse		Children	
	Yes	No	Yes	No	Yes	No		Yes	No	Yes	No	Yes	No
a. Heart disorder or chest pains	☐	☐	☐	☐	☐	☐	o. Intestinal or kidney disorders	☐	☐	☐	☐	☐	☐
b. Blood disorders	☐	☐	☐	☐	☐	☐	p. Chronic diarrhea	☐	☐	☐	☐	☐	☐
c. Irregular pulse	☐	☐	☐	☐	☐	☐	q. Urinary disorders	☐	☐	☐	☐	☐	☐
d. Circulatory disorders	☐	☐	☐	☐	☐	☐	r. Liver disorders or gallstones	☐	☐	☐	☐	☐	☐
e. Pleurisy, asthma or emphysema	☐	☐	☐	☐	☐	☐	s. Genital disorders	☐	☐	☐	☐	☐	☐
f. Backache, neck or spinal cord disorders	☐	☐	☐	☐	☐	☐	t. Goiter or glandular disorders	☐	☐	☐	☐	☐	☐
g. Lung disorder	☐	☐	☐	☐	☐	☐	u. Neuritis	☐	☐	☐	☐	☐	☐
h. High blood pressure, elevated cholesterol or stroke	☐	☐	☐	☐	☐	☐	v. Arthritis, rheumatism, sciatica, gout, bone, joint disorder or lupus in any form	☐	☐	☐	☐	☐	☐
i. Tumours or cancer	☐	☐	☐	☐	☐	☐	w. Muscular dystrophy	☐	☐	☐	☐	☐	☐
j. Mental disorders	☐	☐	☐	☐	☐	☐	x. Diabetes	☐	☐	☐	☐	☐	☐
k. Mood disorders or other emotional disorders	☐	☐	☐	☐	☐	☐	y. Fibromyalgia or chronic fatigue syndrome	☐	☐	☐	☐	☐	☐
l. Neurological disorders, epilepsy or seizure	☐	☐	☐	☐	☐	☐	z. Any eye, ear or throat disorders	☐	☐	☐	☐	☐	☐
m. Multiple sclerosis	☐	☐	☐	☐	☐	☐	aa. Any health problems related to use of drugs and/or alcohol	☐	☐	☐	☐	☐	☐
n. Stomach disorders or ulcers	☐	☐	☐	☐	☐	☐							

	Member		Spouse		Children	
	Yes	No	Yes	No	Yes	No
7. Are you aware of physical or psychological disorders or abnormalities which have not been revealed in the answers given to questions 1 to 6?	☐	☐	☐	☐	☐	☐
8. Are you aware of any signs or symptoms for which a consultation and/or an examination is necessary and/or is already planned?	☐	☐	☐	☐	☐	☐

9. For alcoholic beverages, tobacco and narcotics or drugs, indicate the weekly consumption. If none, indicate 0. For alcoholic beverages, 1 serving = 1 bottle of beer = 1 glass of wine = 1 ounce of alcohol.
(For legal age children, use another sheet. Date and sign any attached document. Please indicate the first name of each child.)

	Beer	Wine	Alcohol	Tobacco	Narcotics or drugs
Member					
Spouse					

10. Do you currently or do you intend to participate in any professional or hazardous sports activity, such as scuba diving, flying an aircraft, skydiving, car racing, etc.? (Use another sheet if needed. Date and sign any attached document.)

		If yes, please specify which activity and how often.			
Member	☐ Yes ☐ No				
Spouse	☐ Yes ☐ No				
Children	☐ Yes ☐ No	Child's first name		Answer	
		Child's first name		Answer	
		Child's first name		Answer	
		Child's first name		Answer	

Validate and Print

Plan member's name _____ Group policy no. _____ Certificate no. _____

Complete questions 11 and 12 only if you are applying for the Critical Illness Benefit.	**Member** Yes	No	**Spouse** Yes	No	**Children** Yes	No
11. Have you experienced any history of optic neuritis, numbness, tingling, loss of balance, weakness of the extremities, visual disturbance or loss of sensation?	☐	☐	☐	☐	☐	☐
12. Have any of your family members had heart disease, stroke, high blood pressure, cancer, diabetes, kidney disease, Huntington's Chorea, amyotrophic lateral sclerosis (ALS or Gehrig's disease), motor neuron disease, Multiple sclerosis, Alzheimer's disease, colon polyposis or any other hereditary disease?	☐	☐	☐	☐		

13. If you and/or your spouse answered "yes" to question 12, please complete the following table. (Use another sheet if needed. Date and sign any attached document.)

	Identify the family member	**Illnesses (if cancer, please specify)**	**Age at the beginning of the illness**	**Age if living**	**Age at death, if applicable**
Member	☐ Father ☐ Mother ☐ Brother ☐ Sister				
	☐ Father ☐ Mother ☐ Brother ☐ Sister				
Spouse	☐ Father ☐ Mother ☐ Brother ☐ Sister				
	☐ Father ☐ Mother ☐ Brother ☐ Sister				

14. Provide details for each affirmative answer given to questions 1 to 11
(If more space is required, please use another sheet. Date and sign any attached document):

List of affirmative answers...

Question no.	**First name**	**Reason, diagnosis, treatment, medication, surgery, if applicable, results and recommendation**	**Onset of illness or date of test**	**Period during which employment or regular duties could not be performed**	**Complete recovery date**	**Names of physicians and hospitals/clinics**
			Y M D		Y M D	

Validate and Print

Plan member's name _____ Group policy no. _____ Certificate no. _____

CONFIRMATION/AUTHORIZATION

I HEREBY CONFIRM that the statements contained in this form and in any document attached hereto or given during a phone interview are complete and true, and **I AUTHORIZE** the release of the information to Industrial Alliance Insurance and Financial Services Inc. for the purpose of assessing my insurability under the group plan.

I UNDERSTAND that the requested insurance is governed by the terms of the group insurance policy and will only take effect on the date determined by the terms of the policy once Industrial Alliance approves my insurability.

I AUTHORIZE any healthcare provider or professional, medical organization, insurance or reinsurance company, the MIB Inc., workers' compensation board, the Policyholder, my employer, as well as any other person, public or private organization or institution holding files or information concerning myself, or if applicable, concerning my minor age children, to provide and exchange with Industrial Alliance, its employees, its reinsurers or their authorized agents, any information required to assess my insurability or my minor age children's insurability, under the group plan.

I ALSO AUTHORIZE Industrial Alliance, its employees and its reinsurers, to exchange with its subsidiaries and other insurers or financial institutions, the personal information obtained to review my insurability, or, if applicable, my minor age children's insurability, and to make inquiries so as to allow them to assess the risk.

I ALSO AUTHORIZE Industrial Alliance to send any abnormal test results to my personal physician.

I ALSO AUTHORIZE Industrial Alliance and its reinsurers to make a brief report of my personal health information to MIB.

This confirmation/authorization is valid for the purposes of the current group insurance policy. **A photocopy of this confirmation/authorization has the same value as the original.**

Date Y M D _____ Plan member's signature **X** _____

This section must be filled out by hand.

Spouse's signature **X** _____

Signature(s) of legal age child(ren) **X** _____

AUTHORIZATION

I AUTHORIZE any healthcare provider or professional, medical organization, insurance or reinsurance company, the MIB Inc., workers' compensation board, the Policyholder, my employer, as well as any other person, public or private organization or institution holding files or information concerning myself, or if applicable, concerning my minor age children, to provide and exchange with Industrial Alliance, its employees, its reinsurers or their authorized agents any information required to assess my insurability or my minor age children's insurability, under the group plan.

This authorization is valid for the purposes of the current group insurance policy. **A photocopy of this authorization has the same value as the original.**

Date Y M D _____ Plan member's signature **X** _____

This section must be filled out by hand.

Spouse's signature **X** _____

Signature(s) of legal age child(ren) **X** _____

WHERE TO SUBMIT THIS FORM?

If you are a new plan member, please submit this form by:

Fax: 1-877-392-6487

Mail:

Quebec
Administration
PO Box 790, Station B
Montreal, Quebec H3B 3K6

All Other Provinces
Administration
522 University Avenue, Suite 400
Toronto, Ontario M5G 1Y7

If you are an existing plan member, please submit this form by:

Fax: 1-888-780-3486

Mail:
Medical Underwriting
PO Box 790, Station B
Montreal, Quebec H3B 3K6

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THIS PAGE IS TO BE KEPT ON FILE BY THE PLAN MEMBER.

PRE-NOTICE FROM THE MIB INC.

Information regarding your insurability will be treated as confidential. Industrial Alliance Insurance and Financial Services Inc. and its reinsurers may, however, make a brief report thereon to the MIB Inc., a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health coverage, or if a claim for benefits is submitted to such a company, the MIB will supply such company with the information it may have in its files upon request.

Upon receipt of a request from you, the MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of the information contained in the MIB's files, you may contact them and request a correction. The address of the MIB's information office is: MIB, 330 University Avenue, Suite 501, Toronto, Ontario M5G 1R7, telephone: 416-597-0590.

Industrial Alliance 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.

NOTICE

In order to consider your request for insurance, we may ask for additional information.

You may be contacted to provide additional information about your health and financial status. When contacted, you may be asked to complete a medical or cognitive examination and provide a blood or urine sample.

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, Information Access Officer, 1080 Grande Allée West, PO Box 1907, Station Terminus, Quebec, 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 duties, individuals to whom you have granted access, and persons authorized by law.

For the purposes of audits and administrative reporting, Industrial Alliance may release to your Employer/Policyholder statistical financial information without personal identifiers.

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