

IMPORTANT: The basic dependents' life insurance coverage will be applied automatically if your plan includes this benefit and your dependents (spouse and children) are eligible. This requirement applies regardless of the coverage chosen for the health and dental benefits (individual, family, single-parent, couple or refused coverage).

2. SPOUSE INFORMATION

First name _____ Last name _____

Date of birth

Y			M				D		

Gender: Male Female

Does your spouse already have health and/or dental coverage under another group plan? Yes No

If yes, specify your spouse's:

Health coverage: Individual Family Single-parent Couple

Effective date:

Y			M				D		

Dental coverage: Individual Family Single-parent Couple

Effective date:

Y			M				D		

Insurer's name _____

Group policy no. _____ Certificate no. _____

Note: If your spouse is a common-law spouse, please contact your plan administrator to confirm his/her eligibility.

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

First name	Last name	Gender	Date of birth	If age 21* or over, specify																				
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Y			M				D																	

* The age limit may vary depending on your plan. Please contact your plan administrator to confirm this information.

If any of your dependent children have coverage under a group insurance plan other than yours or your spouse's, complete the following table:

Child First name, Last name	Plan type (e.g. school plan, etc.)	Insurer name	Group policy no.

4. CHOICE OF COVERAGE

Coverage requested: Individual Family Single-parent ¹ Couple ¹

¹ Select this coverage only if offered by your plan. Please be advised that if the single-parent and couple categories are not offered, you will automatically have family coverage.

Specify: Option/Module/Plan (if applicable) _____

If you and/or your dependents already have health and/or dental coverage under another group plan, you can refuse health and/or dental coverage under this group plan by checking the following boxes:

For myself and my dependents: I refuse health coverage I refuse dental coverage

For my dependents only: I refuse health coverage I refuse dental coverage

Note: If you refuse coverage and wish to request it at a later date, certain conditions may apply. Please contact your plan administrator for further details.

At Industrial Alliance Insurance and Financial Services Inc. ("iA Financial Group"), 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 information will be kept at iA Financial Group's offices.

You have the right to request access to your personal information and, if necessary, correct any inaccurate information. To do so, send a written request to: iA Financial Group, 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 employees, agents, reinsurers and service providers of iA Financial Group 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, iA Financial Group may release to your Employer/Policyholder statistical financial information without personal identifiers.