

POLICYHOLDER INFORMATION

Policyholder's name (employer/organization): _____

Group policy no.: _____ Division no.: All divisions
 The following division(s): _____

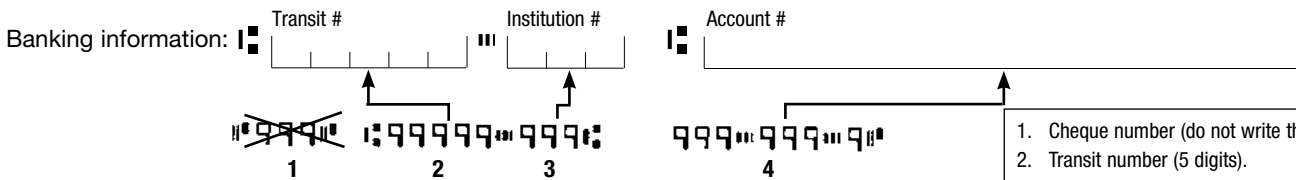
- Regular account(s) – monthly premiums Health spending account(s) (HSA) Wellness account(s) Physical activity account(s)
 Dialogue Administrative services only (ASO) plan(s) Cost Plus agreement(s) Flex Module

BANKING INFORMATION

Name of bank account holder: _____

Name of second bank account holder: _____

(if applicable)



1. Cheque number (do not write this number).
2. Transit number (5 digits).
3. Financial institution number (3 digits).
4. Account number. The format may vary from one financial institution to another. **Indicate all numbers and only the numbers.**

Note: You can include with this form a cheque marked VOID or a complete written confirmation from your financial institution to avoid transcription errors.

IMPORTANT: You must notify Industrial Alliance Insurance and Financial Services Inc. of any change in your banking information for pre-authorized debits.

TIMING OF PRE-AUTHORIZED DEBITS

Please select one of the following dates* for the premiums to be withdrawn from your bank account:

- 1st day of each month 5th day of each month 10th day of each month 15th day of each month

Note: If you do not select a date, the default date will be the 10th day of each month.

*For Flex Module, premiums will be withdrawn on the 10th day of each month.

For health spending accounts (HSAs), wellness accounts, physical activity accounts, Dialogue and Cost Plus agreement(s), charges will be withdrawn on the 15th day of each month.

For administrative services only (ASO) plans, premiums will be withdrawn according to the frequency indicated in the financial agreement.

PRE-AUTHORIZED DEBIT AGREEMENT

In this pre-authorized debit (PAD) agreement, "I" refers to each bank account holder or authorized signer who, as it regards them, declares as follows:

Authorization

I authorize Industrial Alliance Insurance and Financial Services Inc. (the "Company") and the financial institution designated above (or any other financial institution I may authorize at any time) to perform PADs from the bank account designated above (or any other account I may designate at any time), for payment of premiums, taxes, deposits, instalments and charges for the policy and division(s) to which this agreement is attached. Regular periodic PADs will be processed on the date and at the frequency specified above, whereas occasional one-time PADs can be processed on any other date.

If a PAD is refused for any reason (e.g., non-sufficient funds ["NSF"], stop payment, closed account, etc.), the Company is authorized to attempt the PAD again. Costs incurred by the Company resulting from the denied PAD will be added to the next PAD.

PRE-AUTHORIZED DEBIT AGREEMENT (continued)

Variable PAD amount

I agree that the amount of the PAD may vary from month to month due to administrative readjustments calculated by the Company depending on the information relating to management of the policy designated above.

Waiver

I agree to waive my right to receive notification of changes to the amount (upward or downward), the date or the frequency of the PADs, made at my request or at the request of the Company.

Assignment

I acknowledge that the Company may not assign this agreement without notifying me in writing at any time before the next PAD.

Change or cancellation

I will notify the Company within a reasonable timeframe of any change made to this agreement. Where there is a change to my banking information, I will notify the Company in writing at least 10 days prior to the next PAD.

I may cancel this agreement, subject to providing written notice to the Company 30 days prior to the next PAD. Any cancellation of this agreement will not affect my insurance contract(s) and/or contract(s) for financial services, as long as payment is provided by an alternate method. For more information on my right to cancel the agreement, I may contact my financial institution or visit www.payments.ca.

Reimbursement

I have certain recourse rights if any PAD does not comply with this agreement. For example, I have the right to be reimbursed for any PAD that is not authorized or is not consistent with this agreement. For more information on my recourse rights, I may contact my financial institution or visit www.payments.ca.

Declaration

I declare that any person whose signature is required to authorize this agreement has signed below.

Name of bank account holder or authorized signer

Email

Signature of bank account holder or authorized signer

Date Y M D
|_| |_| |_| |_| |_| |_|

If the account requires two signatures:

Name of second bank account holder or authorized signer

Email

Signature of second bank account holder or authorized signer

Date Y M D
|_| |_| |_| |_| |_| |_|

CONTACT INFORMATION FOR INDUSTRIAL ALLIANCE INSURANCE AND FINANCIAL SERVICES INC.

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