

Please print in ink and sign.

1. GENERAL INFORMATION

Policyholder's name _____ Group policy no. _____
 (Employer/organization)

2. NEW REQUEST OR ACCESS CHANGE (For additional access requests, please complete the appendix on pages 3 and 4)

Administrator information (All fields MUST BE completed)	Type of access	Divisions
First name _____ Last name _____ Address of organization _____ <small style="margin-left: 150px;">Civic number, street, suite</small> _____ <small style="margin-left: 100px;">City, province, postal code</small> Email _____ Language: <input type="checkbox"/> English <input type="checkbox"/> French	<input type="checkbox"/> All transactions <input type="checkbox"/> View only <input type="checkbox"/> Invoice view only	<input type="checkbox"/> All divisions <input type="checkbox"/> Specific division(s): _____ _____
Administrator information (All fields MUST BE completed)	Type of access	Divisions
First name _____ Last name _____ Address of organization _____ <small style="margin-left: 150px;">Civic number, street, suite</small> _____ <small style="margin-left: 100px;">City, province, postal code</small> Email _____ Language: <input type="checkbox"/> English <input type="checkbox"/> French	<input type="checkbox"/> All transactions <input type="checkbox"/> View only <input type="checkbox"/> Invoice view only	<input type="checkbox"/> All divisions <input type="checkbox"/> Specific division(s): _____ _____
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Read and complete the back of the page and sign the section "POLICYHOLDER TERMS OF USE."

3. ACCESS CANCELLATION

Name of administrator(s) whose access must be cancelled		Effective date		
First name	Last name	Y	M	D
_____	_____			
_____	_____			
_____	_____			

4. ADMINISTRATOR TERMS OF USE

The administrator **AGREES** to use My Client Space strictly for the plan administration of his/her division or group and according to the type of access authorized by his/her policyholder.

The administrator **UNDERSTANDS** that the use of his/her access code and password are equivalent to his/her signature and that he/she is responsible for ensuring that this information remains confidential at all times.

The administrator **UNDERSTANDS** that for reasons of security and data confidentiality, it is forbidden to share access codes or use those of others to connect to My Client Space.

The administrator **AGREES** to maintain and protect the privacy and confidentiality of the personal information of plan members found in My Client Space, in accordance with provincial and federal laws and regulations.

If the administrator performs transactions via My Client Space, he/she **AGREES** to administer the plan in accordance with the terms and conditions of the Group Policy.

The administrator **UNDERSTANDS** that his/her access to My Client Space can be revoked at any time without notice.

5. POLICYHOLDER TERMS OF USE

As authorized signatory, I hereby **AUTHORIZE** the administrator(s) named in section 2. New Request or Access Change and, if applicable, in Appendix - Additional Access Requests, on page 3 and 4, to have access to My Client Space for administration purposes only and according to the type of access authorized.

I ACCEPT all responsibility in the event that the information contained in My Client Space is misused as a result of the accesses authorized herein.

I CONFIRM that the administrator(s) has (have) read and accepted the Administrator Terms of Use above.

I ACKNOWLEDGE and **AGREE** that My Client Space is the sole and exclusive property of Industrial Alliance Insurance and Financial Services Inc. ("iA Financial Group") and shall not be copied, downloaded or retransmitted for any use other than that specified by iA Financial Group or to any party without the prior written consent of iA Financial Group.

I AGREE to cancel the My Client Space access rights of administrators that leave the organization.

I UNDERSTAND that iA Financial Group may revoke the My Client Space access of any administrator at any time.

I AGREE that a photocopy of my signature below shall be as valid as the original.

First name _____ Last name _____
Please print Please print

Signature _____ Date _____
Y M D
| | | | | |

Phone _____ Email _____

WHERE SHOULD THE COMPLETED FORM BE SUBMITTED?

Email: groupinsurance@ia.ca

Fax: 1-877-392-6487

Mail: Quebec

All other provinces

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

PO Box 4643, Station A
Toronto, Ontario M5W 5E3

APPENDIX - ADDITIONAL ACCESS REQUESTS

<p>Administrator information (All fields MUST BE completed)</p> <p>First name _____</p> <p>Last name _____</p> <p>Address of organization _____ <small>Civic number, street, suite</small></p> <p>_____</p> <p><small>City, province, postal code</small></p> <p>Email _____ Language: <input type="checkbox"/> English <input type="checkbox"/> French</p>	<p>Type of access</p> <p><input type="checkbox"/> All transactions</p> <p><input type="checkbox"/> View only</p> <p><input type="checkbox"/> Invoice view only</p>	<p>Divisions</p> <p><input type="checkbox"/> All divisions</p> <p><input type="checkbox"/> Specific division(s):</p> <p>_____</p> <p>_____</p>
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APPENDIX - ADDITIONAL ACCESS REQUESTS

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