Underwritten by:
Industrial Alliance Insurance & Financial Services Inc.
400–988 Broadway W PO Box 5900, Vancouver, BC V6B 5H6

FOR OFFICE USE ONLY

DEPENDENT CHILD CRITICAL ILLNESS INSURANCE APPLICATION FOR LATE APPLICANTS

Please print in ink or complete online and print

POLICY INFORMATION

Name of Policyholder	Group Policy No.	Division No.	Member/Employee ID

EMPLOYEE INFORMATION MUST ALWAYS BE COMPLETED

Last Name	Given Name	Initials	Gender	Date of Birth (dd-mmm-yyyy)
			☐ Male ☐ Female	

Place of Birth	Occupation

Street Address	City	Prov.	Postal Code
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Telephone (Home)	Telephone (☐ Work ☐ Cell)	Email

DEPENDENT CHILD(REN) INFORMATION

Reason for late application	Amount of Dependent Critical Illness Insurance applying for

Full name of each Dependent Child to be insured (children, step-children, and legally adopted children)	Gender	Date of Birth (dd-mmm-yyyy)	Which best describes your dependent? Select One	Height	Weight
	☐ Male ☐ Female		☐ Child ☐ Full-Time Post Secondary Student	☐ in ☐ cm	☐ lb ☐ kg
	☐ Male ☐ Female		☐ Child ☐ Full-Time Post Secondary Student	☐ in ☐ cm	☐ lb ☐ kg
	☐ Male ☐ Female		☐ Child ☐ Full-Time Post Secondary Student	☐ in ☐ cm	☐ lb ☐ kg
	☐ Male ☐ Female		☐ Child ☐ Full-Time Post Secondary Student	☐ in ☐ cm	☐ lb ☐ kg
	☐ Male ☐ Female		☐ Child ☐ Full-Time Post Secondary Student	☐ in ☐ cm	☐ lb ☐ kg

Are all Dependent Children to be insured in good health and free from any symptoms and/or diagnosis or any illness, disease, disorder, or any physical or mental abnormalities?

If 'No', provide name of Dependent Child and details

☐ Yes ☐ No

Do any of your Dependent Children intend to travel or reside outside Canada or the United States for more than one month?

If 'Yes', provide details including name of Dependent Child, dates of travel, cities and countries and reason

☐ Yes ☐ No

Have any of the proposed Dependent Children ever applied for any insurance that was declined, modified or rated?

If "Yes", provide details including name of Dependent, date, name of company and reason

☐ Yes ☐ No

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FAMILY HISTORY QUESTION MUST ALWAYS BE COMPLETED WHEN APPLYING

Have any of the dependent child's biological parents, grandparents, brothers or sisters ever undergone bypass surgery or suffered from any of the following conditions: Heart attack, angina, or any other heart condition, stroke, polycystic kidney disease, diabetes, cancer (if "Yes", specify type), Alzheimer's disease, Parkinson's disease, multiple sclerosis, amyotrophic lateral sclerosis (ALS), Huntington's disease, alcoholism, nervous or mental disorder, or any other hereditary disease?

Yes ○ **No** ○

If "Yes", please complete the following table. If you require more space, please attach a separate sheet of paper, signed and dated.

	Condition	Age at Onset/ Diagnosis	Age at Death (if applicable)
Father			
Mother			
Brothers			
Sisters			
Maternal Grandparents			
Paternal Grandparents			

AUTHORIZATION FORM MUST BE SIGNED IN INK

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

a) any health care professional as well as any other public or private health or social service establishment, any insurance company, the Medical Information Bureau, any insurance plan sponsor, any agent, broker or market intermediary, any third party administrator, any personal information agents or professional investigation agencies and any government agency, or other organization, institution or person that has any records or knowledge of my or my dependent child's, to give to Industrial Alliance Insurance and Financial Services Inc. (the "Company") or its reinsurers any such information for the purpose of the risk assessment, administration or investigation of a subsequent claim.

b) the Company or its reinsurers to release and exchange any personal information obtained to the above persons and organizations for the purposes of assessment of this application, the administration of any certificate issued and the investigation of any claim.

c) the Company to test and evaluate a specimen of my blood, urine or saliva for the purpose of assessing my dependent child as an insurance risk. This analysis includes testing for HIV infection.

d) the Company to release any abnormal test results to my dependent child's personal physician.

I acknowledge that all correspondence relating to this application, including the requirement for additional medical information and the communication of any underwriting decision, will be directed to the employee.

I further acknowledge receipt of the Notice on Privacy and Confidentiality (attached) summarizing certain privacy practices regarding collection, use and disclosure of my or my dependent child's personal information.

I agree to the use of my or my dependent child's personal information for the purposes outlined in this application. I understand that my consent to the use of any information to offer me products and services is optional and that if I wish to discontinue such use I may call or write to the Company at the telephone number or address shown on this application.

I confirm that the foregoing answers, forming part of an application for group insurance to the Company are true, full, complete and correctly recorded, and together with any other forms signed by me in connection with this application form the basis for any certificate issued hereunder. 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 the Company of any change in my or my dependent child's health or insurability. I agree that my insurance will not take effect until my properly completed application has been approved by the Company and the first month's premium has been paid.

A copy of this signed authorization shall be as valid as the original.

x _____ Date (dd-mmm-yyyy) _____

Employee Signature (must always sign)

x _____ Date (dd-mmm-yyyy) _____

Dependent Signature (if 16 or older)

x _____ Date (dd-mmm-yyyy) _____

Dependent Signature (if 16 or older)

x _____ Date (dd-mmm-yyyy) _____

Dependent Signature (if 16 or older)

NOTICE ON PRIVACY & CONFIDENTIALITY PLEASE READ CAREFULLY AND RETAIN FOR YOUR RECORDS

The specific and detailed information requested pursuant to this application from you and which may be subsequently requested by us, from time to time, is required to process your application, and process any claim for benefits made by you. To protect the confidentiality of such personal information, access to your information is restricted to any person you authorize or as authorized by law as well as those Industrial Alliance Insurance and Financial Services Inc. (the "Company") employees, its reinsurers, third party administrators, agents or brokers of the Company, plan sponsors and any agents or brokers of such sponsors or other market intermediaries for the purposes of (a) sponsoring a plan for you, (b) marketing and administration of Company products or services, (c) assessment of risk (underwriting) and (d) investigation of claims (where applicable). **Your file will be kept in our offices.**

You are entitled to review your personal information contained in our files, subject to certain limited exceptions established by law, and if necessary, to have it rectified by sending a written request to us at: 400–988 West Broadway. PO. Box 5900, Vancouver, BC V6B 5H6, Attention: Director, iA Special Markets. Corrections will be noted in the file. If a requested correction is in dispute, we nonetheless note your requested correction in the file. Further information on our privacy practices can be found online at ia.ca or alternatively, contact us at 1.800.266.5667 and request that a copy be faxed or mailed to you.

DISCLOSURE NOTICE - MEDICAL INFORMATION BUREAU PLEASE READ CAREFULLY AND RETAIN FOR YOUR RECORDS

Information regarding your insurability will be treated as confidential. Industrial Alliance Insurance and Financial Services Inc. (the "Company") and its reinsurers may, however, make a brief report thereon to the Medical Information Bureau (MIB), 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 insurance coverage, or a claim for benefits is submitted to such company, MIB, upon request, will supply that company with the information it may have in its files.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction. The address of MIB's Information office is: Medical Information Bureau, 330 University Avenue, Toronto, Ontario, Canada M5G 1R7, telephone number (416) 597-0590.

The Company 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.

SEND YOUR COMPLETED FORM TO

iA Special Markets
Industrial Alliance Insurance and Financial Services Inc.
400–988 Broadway W, PO Box 5900, Vancouver, BC V6B 5H6

QUESTIONS?

Contact a Client Service Specialist at:
1.800.266.5667 (toll-free)
604.737.3802 (Vancouver)
specialmarkets@ia.ca
Monday to Friday 6:30 a.m. - 4:30 p.m. Pacific Time