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**GROUP INSURANCE**

# Evidence of insurability

## Disclosure

At Industrial Alliance, the personal information we collect concerning you and your dependants 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 Insurance and Financial Services Inc., 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 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.

## 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.

**A PARTNER YOU CAN TRUST.**

**I- Policyholder's Statement**

Policyholder's name (employer or organization)	Policy no.	Division no.	Class no.
Member's name	Certificate number		

**1. What is the reason for completing this form?**

Amount of insurance in excess of the maximum without evidence of insurability  Life  Disability Income  Critical Illness

Application for optional life insurance

	Amount		
	Current	+ Requested	= Total
Member			
Spouse			
Children			

Application for optional critical illness

	Amount		
	Current	+ Requested	= Total
Member			
Spouse			
Children			

Late request for membership  
**Specify the reason:**

Late request for coverage of dependents. Was the spouse (and children, if any) covered under another employer's group plan?  
Yes  No

**If yes, specify:**

Employer's name \_\_\_\_\_  
Insurer's name \_\_\_\_\_  
Coverage termination date \_\_\_\_\_  
Policy no. \_\_\_\_\_ Certificate no. \_\_\_\_\_

**2. Is the member effectively at work and physically able to perform all work-related duties?**

Yes  No  If not, explain: \_\_\_\_\_  
Date \_\_\_\_\_ Policyholder's authorized signature \_\_\_\_\_

**II- Member's Statement (Please print in ink.)**

Please provide the information requested for the proposed insureds only.

Language:  English  French

<input type="checkbox"/> <b>Member</b>	Height	Weight <input type="checkbox"/> lbs. <input type="checkbox"/> kg.	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth	Y	M	D
Place of birth		Occupation					
Home address		City/Pr	Postal code	Telephone			
Name and address of attending physician							
Last consultation		Y	M	D	Reason and results		
Date							
<input type="checkbox"/> <b>Spouse</b>	Height	Weight <input type="checkbox"/> lbs. <input type="checkbox"/> kg.	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth	Y	M	D
Name		Occupation					
Place of birth		Occupation					
<input type="checkbox"/> Married/Civil union		<input type="checkbox"/> Common-law spouse since		Y	M	D	
Name and address of attending physician							
Last consultation		Y	M	D	Reason and results		
Date							

<input type="checkbox"/> <b>Children</b>	Date of birth							
Name		Y	M	D				
Height	Weight <input type="checkbox"/> lbs. <input type="checkbox"/> kg.	Sex <input type="checkbox"/> M <input type="checkbox"/> F						
Name		Y	M	D				
Height	Weight <input type="checkbox"/> lbs. <input type="checkbox"/> kg.	Sex <input type="checkbox"/> M <input type="checkbox"/> F						
Name		Y	M	D				
Height	Weight <input type="checkbox"/> lbs. <input type="checkbox"/> kg.	Sex <input type="checkbox"/> M <input type="checkbox"/> F						
Name		Y	M	D				
Height	Weight <input type="checkbox"/> lbs. <input type="checkbox"/> kg.	Sex <input type="checkbox"/> M <input type="checkbox"/> F						
Name		Y	M	D				
Height	Weight <input type="checkbox"/> lbs. <input type="checkbox"/> kg.	Sex <input type="checkbox"/> M <input type="checkbox"/> F						

**Any of the proposed insureds (including the spouse and children, if any):**

Member		Spouse		Children	
Yes	No	Yes	No	Yes	No

- |  |   |   |   |   |   |   |
|--|---|---|---|---|---|---|
| 1. Are any of the proposed insureds (including spouse and children, if any) currently taking medication or following a diet? If yes, indicate the name(s) of the medication or diet _____  | □ | □ | □ | □ | □ | □ |
| 2. Have any of the proposed insureds:  |   |   |   |   |   |   |
| a. been absent from work due to illness or injury in the last 6 months?  | □ | □ | □ | □ | □ | □ |
| b. been hospitalized in a hospital or other medical institution for observation, rest, diagnosis or treatment?   | □ | □ | □ | □ | □ | □ |
| c. 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?                                  | □ | □ | □ | □ | □ | □ |
| d. other than medication prescribed by a physician, ever used barbiturates, heroin, opiates or other narcotics?  | □ | □ | □ | □ | □ | □ |
| e. ever attended a treatment program for drug abuse or were advised to do so?  | □ | □ | □ | □ | □ | □ |
| f. ever been advised to stop drinking or attended a treatment program for alcohol abuse?   | □ | □ | □ | □ | □ | □ |
| g. undergone or been advised to undergo: <input type="checkbox"/> an examination for diagnostic purposes <input type="checkbox"/> an electrocardiogram <input type="checkbox"/> an x-ray (nature, date, and results) <input type="checkbox"/> a scan or magnetic resonance imaging <input type="checkbox"/> other test (specify) _____ | □ | □ | □ | □ | □ | □ |
| h. had 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?   | □ | □ | □ | □ | □ | □ |
| i. requested or received benefits, compensation or an annuity due to illness or injury?  | □ | □ | □ | □ | □ | □ |
| j. in the last 12 months, used tobacco in any form whatsoever, including tobacco or nicotine products (gum, patches, etc.)?  | □ | □ | □ | □ | □ | □ |



**6. CONSUMPTION OF ALCOHOL, TOBACCO AND OTHER SUBSTANCES:** Indicate the weekly consumption of alcoholic beverages, tobacco, narcotics and/or drugs.  
(1 serving of alcohol = 1 glass of wine = 1 bottle of beer = 1 ounce of alcohol)

Participant				
Beer	Wine	Alcohol	Tobacco	Narcotics or drugs

Spouse				
Beer	Wine	Alcohol	Tobacco	Narcotics or drugs

**7. Critical Illness Insurance: Additional Questions**  
(Questions 7 a. and b. only need to be completed if you are applying for the Critical Illness Benefit)  
For each affirmative answer given below, please provide details in the table on the previous page (Question 5).

Member	Spouse	Children			
Yes	No	Yes	No	Yes	No

a. Have any of the proposed insureds experienced any history of optic neuritis, numbness, tingling, loss of balance, weakness of the extremities, visual disturbance or loss of sensation?

**b. FAMILY HISTORY**

Have any of your family members had heart disease, stroke, high blood pressure, cancer (specify type), diabetes, kidney disease, Huntington's Chorea, amyotrophic lateral sclerosis (ALS/Lou Gehrig's disease), motor neuron disease, Multiple Sclerosis, Alzheimer's Disease or any other hereditary disease?

Member  Yes  No Spouse  Yes  No If yes, specify below.

	Identify the family member	Illnesses (if cancer, please specify)	Age at the beginning of the illness	Age if living	Age at death
<b>Member</b>	<input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Brother <input type="checkbox"/> Sister				
	<input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Brother <input type="checkbox"/> Sister				
<b>Spouse</b>	<input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Brother <input type="checkbox"/> Sister				
	<input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Brother <input type="checkbox"/> Sister				

**III- Confirmation/Authorization**

**I HEREBY CONFIRM** that the statements contained in this Evidence of Insurability form and in any document attached hereto or given during a phone interview are complete and true, and **AUTHORIZE** the release of the information to Industrial Alliance 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 Medical Information Bureau, 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 child'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 child'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.

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 


 Member's signature \_\_\_\_\_ Spouse's signature \_\_\_\_\_  
Signature of legal age child \_\_\_\_\_

**IV- Authorization**

**I AUTHORIZE** any healthcare provider or professional, medical organization, insurance or reinsurance company, the Medical Information Bureau, 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 child's insurability, under the group plan.

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

Date 


 Member's signature \_\_\_\_\_ Spouse's signature \_\_\_\_\_  
Signature of legal age child \_\_\_\_\_

**Pre-notice from the Medical Information Bureau (Must be detached and kept by the member)**

Information regarding your insurability will be treated as confidential. Industrial Alliance and its reinsurers may, however, make a brief report thereon to the Medical Information Bureau, 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: Medical Information Bureau, 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.