


Evidence of Insurability

If the *Enrolment Request* form is submitted more than 31 days after the eligibility date, evidence of insurability will be required. The employee must complete and sign in ink the *Evidence of Insurability* form (F54-002A).


 INDUSTRIAL ALLIANCE INSURANCE AND FINANCIAL SERVICES INC.		Quebec PO Box 790, Station B Montreal, Quebec H3B 3K6	Ontario, Atlantic and Western Provinces 522 University Avenue, Suite 400 Toronto, Ontario M5G 1Y7	EVIDENCE OF INSURABILITY															
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? <input type="checkbox"/> Amount of insurance in excess of the maximum without evidence of insurability <input type="checkbox"/> Life <input type="checkbox"/> Disability Income <input type="checkbox"/> Critical Illness																			
<input type="checkbox"/> Application for optional life insurance		<table border="1"> <tr><th colspan="3">Amount</th></tr> <tr><th>Current</th><th>+ Requested</th><th>= Total</th></tr> <tr><td>Member</td><td></td><td></td></tr> <tr><td>Spouse</td><td></td><td></td></tr> <tr><td>Children</td><td></td><td></td></tr> </table>		Amount			Current	+ Requested	= Total	Member			Spouse			Children			<input type="checkbox"/> Late request for membership Specify the reason: _____
Amount																			
Current	+ Requested	= Total																	
Member																			
Spouse																			
Children																			
<input type="checkbox"/> Application for optional critical illness		<table border="1"> <tr><th colspan="3">Amount</th></tr> <tr><th>Current</th><th>+ Requested</th><th>= Total</th></tr> <tr><td>Member</td><td></td><td></td></tr> <tr><td>Spouse</td><td></td><td></td></tr> <tr><td>Children</td><td></td><td></td></tr> </table>		Amount			Current	+ Requested	= Total	Member			Spouse			Children			<input type="checkbox"/> Late request for coverage of dependents. Was the spouse (and children, if any) covered under another employer's group plan? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, specify: Employer's name _____ Insurer's name _____ Coverage termination date _____ Policy no. _____ Certificate no. _____
Amount																			
Current	+ Requested	= Total																	
Member																			
Spouse																			
Children																			
2. Is the member effectively at work and physically able to perform all work-related duties? Yes <input type="checkbox"/> No <input type="checkbox"/> 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: <input type="checkbox"/> English <input type="checkbox"/> French																			
<input type="checkbox"/> Member Height _____ Weight _____ 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 _____				<input type="checkbox"/> Children Date of birth _____ Y _____ M _____ D _____ Name _____ Height _____ Weight _____ lbs. <input type="checkbox"/> kg. Sex <input type="checkbox"/> M <input type="checkbox"/> F															

F54-002A

2 - TERMINATION OF EMPLOYMENT

2.1. Employment Terminated (cancellation of insurance)

On the *Notice of Change* form (F54-020A), indicate code 40 and the last day at work.

 INDUSTRIAL ALLIANCE INSURANCE AND FINANCIAL SERVICES INC. www.inalco.com		GROUP INSURANCE NOTICE OF CHANGE			
Quebec PO Box 790, Station B Montreal, Quebec H3B 3K6	Ontario, Atlantic and Western Provinces 522 University Avenue, Suite 400 Toronto, Ontario M5G 1Y7	Policyholder's name (Employer/Organization) ABC ENTERPRISES INC	Policy number _____		
		Account number _____			
(1) Certificate number	(2) Member's name	(3) Code (see below)	(4) Effective date of change(s) (YY/MM/DD)	(5) Salary Amount Frequency No. of hours	(6) Additional information
321 789 456	ROBERT TOSTLER	40			TERMINATION OF EMPLOYMENT

F54-020A

Conversion of Group Life Insurance

An employee's Basic and/or Optional Life coverage may be converted to an Individual Policy at termination of employment, subject to the conversion privilege. It may also be converted to an Individual Policy for a spouse upon the death of an employee.

The Life coverage can be converted only if applied for within 31 days of the date the coverage is terminated. Make sure the employee or spouse is aware of this time limit.

Converting Life Coverage to an Individual Policy

1. Determine whether the conversion privilege is applicable under the terms of the *Life Insurance Benefit* and *Optional Life Insurance Benefit for Spouse* provisions in your Group Insurance Policy.
2. Have the employee or spouse complete and sign a *Group Life Insurance Conversion Notice* form if the conversion privilege is applicable.
3. Have the employee mail the completed form to the specified address.

2.2. Temporary layoff

Indicate code 43 on the *Notice of Change* form (F54-020A).

Note: Refer to the *Termination of Insurance* section in your group insurance contract, to learn more about the specific stipulations regarding this clause.

(1) Certificate number		(2) Member's name	(3) Code (see below)	(4) Effective date of change(s) (YY/MM/DD)	(5) Salary			(6) Additional information
					Amount	Frequency	No. of hours	
321 789 456		ROBERT TOSTLER	43					

F54-020A

3 - RETURN TO WORK

Refer to the *Reinstatement of Insurance* section of your group insurance contract to establish if the duration of the absence allows a reinstatement of coverage or if you need to enrol the member as a new one.

3.1. Return to Work Following Termination or Temporary Layoff


- › If the duration of the absence was shorter than the period in your contract for which coverage can be reinstated without an eligibility period; indicate code 31 on the *Notice of Change* form (F54-020A).
- › If the duration of the absence was more than the period stipulated in your contract: follow the same procedure specified in section 1, "New Employee."

(1) Certificate number		(2) Member's name	(3) Code (see below)	(4) Effective date of change(s) (YY/MM/DD)	(5) Salary			(6) Additional information
					Amount	Frequency	No. of hours	
321 789 456		ROBERT TOSTLER	31					

F54-020A

3.2. Return from an Absence Caused by Disability

Complete the *Notice of Return to Work* form (F54-268A), specify the type of return (gradual, part time or full time) and the number of hours worked per week.



INDUSTRIAL ALLIANCE
INSURANCE AND FINANCIAL SERVICES INC.

www.inalco.com

GROUP INSURANCE

NOTICE OF RETURN TO WORK

According to your region, please submit completed form to:

Quebec
PO Box 800, Station Maison de la Poste
Montreal, Quebec H3B 3K5

Ontario, Atlantic and Western Provinces
522 University Avenue, Suite 400
Toronto, Ontario M5G 1Y7

Last and first name of member (print in ink) _____

No. _____ Street _____ Apartment _____

City _____ Postal Code _____

Name of policyholder (employer) _____

Position held by the member upon his/her return to work _____

Comments: _____

Policy Number _____ Div. _____

Certificate Number _____

Date of return to work _____

Y | M | D

Full-time
 Part-time
 Gradual return


Date: _____
By: _____
Title: _____
Tel.: (_____) _____

F54-268A (07-11)

F54-268A

4 - SALARY CHANGE

Indicate the salary change on the *Notice of Change* form (F54-020A), specify code 5 and send it to us within 31 days of the change. If the change is received in our office more than 31 days after the effective date of the change, the salary change will be effective on the date the request is received.



INDUSTRIAL ALLIANCE
INSURANCE AND FINANCIAL SERVICES INC.

www.inalco.com

GROUP INSURANCE

NOTICE OF CHANGE

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

Ontario, Atlantic and Western Provinces
522 University Avenue, Suite 400
Toronto, Ontario M5G 1Y7

Policyholder's name (Employer/Organization)
ABC ENTERPRISES INC.

Policy number _____


Account number _____

(1) Certificate number	(2) Member's name	(3) Code (see below)	(4) Effective date of change(s) (YY/MM/DD)	(5) Salary			(6) Additional information
				Amount	Frequency	No. of hours	
321 789 456	ROBERT TOSTLER	5					

F54-020A

Evidence of Insurability

If the salary increase exceeds the maximum available without the evidence of insurability stipulated in your contract, attach the *Evidence of Insurability* form (F54-002A), completed and signed (in ink), to the *Notice of Change* (F54-020A) form.


 INDUSTRIAL ALLIANCE INSURANCE AND FINANCIAL SERVICES INC.		Quebec PO Box 790, Station B Montreal, Quebec H3B 3K6	Ontario, Atlantic and Western Provinces 522 University Avenue, Suite 400 Toronto, Ontario M5G 1Y7	EVIDENCE OF INSURABILITY
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? <input type="checkbox"/> Amount of insurance in excess of the maximum without evidence of insurability <input type="checkbox"/> Life <input type="checkbox"/> Disability Income <input type="checkbox"/> Critical Illness <input type="checkbox"/> Application for optional life insurance <input type="checkbox"/> Application for optional critical illness <input type="checkbox"/> Late request for membership Specify the reason: _____ <input type="checkbox"/> Late request for coverage of dependents. Was the spouse (and children, if any) covered under another employer's group plan? Yes <input type="checkbox"/> No <input type="checkbox"/> 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 <input type="checkbox"/> No <input type="checkbox"/> 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: <input type="checkbox"/> English <input type="checkbox"/> French				
<input type="checkbox"/> Member 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 _____		<input type="checkbox"/> Children Name _____ Date of birth _____ Y M D Height _____ Weight <input type="checkbox"/> lbs. <input type="checkbox"/> kg. Sex <input type="checkbox"/> M <input type="checkbox"/> F		

F54-002A

5 - CHANGE IN THE CLASS OF EMPLOYEE

The employee's coverage depends on the class to which he belongs. If your contract allows for several classes, please advise us of any change in class within 31 days.


Complete the *Notice of Change* form (F54-020A), specifying code 46 and the new class.

 INDUSTRIAL ALLIANCE INSURANCE AND FINANCIAL SERVICES INC. www.inalco.com		GROUP INSURANCE NOTICE OF CHANGE		
Quebec PO Box 790, Station B Montreal, Quebec H3B 3K6		Ontario, Atlantic and Western Provinces 522 University Avenue, Suite 400 Toronto, Ontario M5G 1Y7		Policyholder's name (Employer/Organization) ABC ENTERPRISES INC.
		Policy number	Account number	
(1) Certificate number	(2) Member's name	(3) Code (see below)	(4) Effective date of change(s) (YY/MM/DD)	
321 789 456	ROBERT TOSTLER	46		
			(5) Salary	
			Amount	Frequency
				No. of hours
			(6) Additional information	
			FROM CLASS 100 TO CLASS 110	

F54-020A

8 - MASS CHANGE OF ADDRESSES


On the *Notice of Change* form (F54-020A), indicate the new addresses of the members under "Additional Information" and indicate code 24. Always include the postal code.

 INDUSTRIAL ALLIANCE INSURANCE AND FINANCIAL SERVICES INC. www.inalco.com		GROUP INSURANCE NOTICE OF CHANGE					
Quebec PO Box 790, Station B Montreal, Quebec H3B 3K6	Ontario, Atlantic and Western Provinces 522 University Avenue, Suite 400 Toronto, Ontario M5G 1Y7	Policyholder's name (Employer/Organization) ABC ENTERPRISES INC.	Policy number	Account number			
(1) Certificate number	(2) Member's name	(3) Code (see below)	(4) Effective date of change(s) (YY/MM/DD)	(5) Salary			(6) Additional information
				Amount	Frequency	No. of hours	
321 789 456	ROBERT TOSTLER	24					5555, OXFORD ROAD, TORONTO
123 456 789	KIM BROWN	24					123, 30TH AVE, KINGSTON
123 789 456	KELLY SMITH	24					456, VICTORIA BLVD, ST. JOHN
789 123 456	JUDE SMITH	24					789, WESTMOUND, ST. JOHN

F54-020A

9 - CHANGE OF BENEFICIARY

To change the name or revoke or change the status (revocable/irrevocable) of a member's beneficiary, have the member complete and sign in ink the "Change of Beneficiary" section of the *Change of Record* form (F54-070A). You must take into account the legal provisions below. If the status of the beneficiary previously designated is irrevocable, the irrevocable beneficiary must sign this form in ink.

 INDUSTRIAL ALLIANCE INSURANCE AND FINANCIAL SERVICES INC.		Quebec PO Box 790, Station B Montreal, Quebec H3B 3K6	Ontario, Atlantic and Western Provinces 522 University Avenue, Suite 400 Toronto, Ontario M5G 1Y7	GROUP INSURANCE CHANGE OF RECORD
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10. CHANGE OF BENEFICIARY DESIGNATION (If no beneficiary is designated by the member then the benefit is payable to the estate)					
Last name	First name	Relationship	%	Date of birth	
				Y M D	<input type="checkbox"/> Revocable
					<input type="checkbox"/> Irrevocable
					<input type="checkbox"/> Revocable
					<input type="checkbox"/> Irrevocable

In Quebec, if no choice is made, the designation of the legal spouse is irrevocable and any other choice is revocable. The beneficiary designation above applies to the member's insurance. Dependent claims will be payable to the member. If one of the designated beneficiaries dies before the participant, his share will be distributed proportionately with the other beneficiaries. To replace or make changes to a previously designated irrevocable beneficiary, please obtain his/her signature.

Irrevocable beneficiary's signature _____ Date _____

F54-070A

Revoking a Beneficiary

- › Minors designated as irrevocable beneficiaries cannot renounce their beneficiary rights.
- › If the designation replaces a deceased irrevocable beneficiary, provide proof of death.
- › If the designation replaces an irrevocable beneficiary following a divorce, provide proof of divorce.
- › In all other cases, the irrevocable beneficiary's signature must be obtained.

Beneficiary designation

According to the law, the beneficiary designation indicated on the back of the form is only valid if no prior irrevocable beneficiary designation exists.

In Quebec, the designation of the legal spouse is irrevocable, unless otherwise stipulated, and any other designation is revocable, unless otherwise stipulated. If the revocability or irrevocability of the designation is not clearly indicated through a check mark in the appropriate box on this form, the legal provisions described above apply.

11 - TRANSFER OF DIVISION

Complete the *Notice of Change* form (F54-020A), specifying code 45 and the names of the members who have transferred from one division to another. Please indicate the change in class, if applicable.

(1) Certificate number		(2) Member's name		(3) Code (see below)	(4) Effective date of change(s) (YY/MM/DD)	(5) Salary			(6) Additional information
						Amount	Frequency	No. of hours	
321 789 456		ROBERT TOSTLER		45					FROM CLASS 100 TO CLASS 110

F54-020A

12 - MATERNITY LEAVE, PARENTAL LEAVE

Before the departure date, complete the *Notice of Change* form (F54-020A), specifying:

- › code 75;
- › the date of departure on leave;
- › the expected delivery date, if applicable;
- › the expected date of return.

Note: Any premium adjustment resulting from the Maternity/Parental Leave will be shown with a code 40 on your invoice.

(1) Certificate number		(2) Member's name		(3) Code (see below)	(4) Effective date of change(s) (YY/MM/DD)	(5) Salary			(6) Additional information
						Amount	Frequency	No. of hours	
123 456 789		KIM BROWN		75					MATERNITY LEAVE DEPARTURE DATE
123 456 789		KIM BROWN		75					EXPECTED DELIVERY DATE
123 456 789		KIM BROWN		75					EXPECTED RETURN DATE

F54-020A

13 - OTHER LEAVE OF ABSENCE (EXCEPT LAYOFF – SEE TERMINATION SECTION 2.2)

Before the departure date, complete the *Notice of Change* form (F54-020A), specifying:

- › code according to the nature of absence;
- › the date of departure on leave;
- › the expected date of return;
- › specify any benefits that should be terminated according to the provisions stated in your contract.

(1) Certificate number		(2) Member's name		(3) Code (see below)	(4) Effective date of change(s) (YY/MM/DD)	(5) Salary			(6) Additional information
						Amount	Frequency	No. of hours	
123 789 456		KELLY SMITH		X					UNPAID LEAVE DEPARTURE DATE
123 789 456		KELLY SMITH		X					UNPAID LEAVE RETURN DATE

F54-020A

Note: Any premium adjustment resulting from the *Other Leave of Absence* will be shown with a code 40 on your invoice.