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GROUP INSURANCE

Evidence of insurability

AT INDUSTRIAL ALLIANCE, IT'S ALL ABOUT YOU!

INDUSTRIAL ALLIANCE
INSURANCE AND FINANCIAL SERVICES INC.

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INDUSTRIAL ALLIANCE
INSURANCE AND FINANCIAL SERVICES INC.

Quebec
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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?

☐ 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

☐ **Member**	Height	Weight ☐ lbs. ☐ kg.	Sex ☐ M ☐ 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 Date Y M D	Reason and results			

☐ **Spouse**	Height	Weight ☐ lbs. ☐ kg.	Sex ☐ M ☐ F	Date of birth Y M D
Name				
Place of birth		Occupation		
☐ Married/Civil union	☐ Common-law spouse since Y M D			
Name and address of attending physician				
Last consultation Date Y M D	Reason and results			

☐ **Children**	Date of birth Y M D	Weight ☐ lbs. ☐ kg.	Sex ☐ M ☐ F
Name		Height	
Name		Height	
Name		Height	
Name		Height	
Name		Height	
Name		Height	

	Member Yes	Member No	Spouse Yes	Spouse No	Children Yes	Children No
1. Are any of the proposed insureds (including spouse and children, if any) currently taking medication or following a diet?. If yes, please 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 the 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: ☐ an examination for diagnostic purposes ☐ an electrocardiogram ☐ an x-ray (nature, date, and results) ☐ a scan or a magnetic resonnance imaging ☐ 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. used tobacco in any form whatsoever, including tobacco or nicotine products (gum, patches, etc.)?	☐	☐	☐	☐	☐	☐

3. Have any of the proposed insureds ever consulted a physician or other medical practitioner, been the subject of an examination or medical follow-up, suffered or been diagnosed or treated or been advised that he/she is suffering from one of the following conditions or diseases:

	Member Yes	Member No	Spouse Yes	Spouse No	Children Yes	Children No
a. Heart disorder or chest pains	☐	☐	☐	☐	☐	☐
b. High blood pressure, elevated cholesterol or stroke	☐	☐	☐	☐	☐	☐
c. Irregular pulse	☐	☐	☐	☐	☐	☐
d. Circulatory disorders	☐	☐	☐	☐	☐	☐
e. Blood disorders	☐	☐	☐	☐	☐	☐
f. Tumours or cancer	☐	☐	☐	☐	☐	☐
g. Lung disorder	☐	☐	☐	☐	☐	☐
h. Pleurisy, asthma or emphysema	☐	☐	☐	☐	☐	☐
i. Backache, neck or spinal cord disorders	☐	☐	☐	☐	☐	☐
j. Mental disorders	☐	☐	☐	☐	☐	☐
k. Mood disorders or other emotional disorders	☐	☐	☐	☐	☐	☐
l. Neurological disorders, epilepsy or seizure	☐	☐	☐	☐	☐	☐
m. Multiple sclerosis	☐	☐	☐	☐	☐	☐
n. Stomach disorders or ulcers	☐	☐	☐	☐	☐	☐
o. Intestinal or kidney disorders	☐	☐	☐	☐	☐	☐
p. Chronic diarrhoea	☐	☐	☐	☐	☐	☐
q. Urinary disorders	☐	☐	☐	☐	☐	☐
r. Liver disorders or gallstones	☐	☐	☐	☐	☐	☐
s. Genital disorders	☐	☐	☐	☐	☐	☐
t. Goitre or glandular disorders	☐	☐	☐	☐	☐	☐
u. Neuritis	☐	☐	☐	☐	☐	☐
v. Arthritis, rheumatism, sciatica, gout, bone, joint disorder or lupus in any form	☐	☐	☐	☐	☐	☐
w. Muscular dystrophy	☐	☐	☐	☐	☐	☐
x. Diabetes	☐	☐	☐	☐	☐	☐
y. Fibromyalgia or chronic fatigue syndrome	☐	☐	☐	☐	☐	☐
z. Any eye, ear or throat disorders	☐	☐	☐	☐	☐	☐
ab. Any health problems related to use of drugs and/or alcohol?	☐	☐	☐	☐	☐	☐

4. Are any of the proposed insureds aware of:

a. physical or psychological disorders or abnormalities which have not been revealed in the answers given to questions 2, 3 and 4?	☐	☐	☐	☐	☐	☐
b. symptoms or complaints regarding their health for which they have not yet consulted a physician or have they been advised to have any diagnostic tests, treatment or surgery which has not yet been completed?	☐	☐	☐	☐	☐	☐

5. Provide details for each affirmative answer given to all the previous questions (Please print in ink)

Question no.	First name	Illness or other reason. Indicate if an operation was performed. Reason for any preventive examination, medical advice, treatment and medication.	Onset of illness Y M D	Period during which regular duties or functions could not be performed.	Complete recovery Y M D	Names and addresses of physicians and hospitals

If more space is required, please use another sheet. Date and sign any attached document.

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

**TO ENSURE THAT YOUR REQUEST IS PROCESSED RAPIDLY,
PLEASE ANSWER ALL QUESTIONS AND OBTAIN ALL REQUIRED SIGNATURES.**

Critical Illness Insurance: Additional Questions
(Questions 7 and 8 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
7. 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?	☐	☐	☐	☐	☐	☐

8. 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?

☐ 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
Member	☐ Father ☐ Mother ☐ Brother ☐ Sister				
	☐ Father ☐ Mother ☐ Brother ☐ Sister				
Spouse	☐ Father ☐ Mother ☐ Brother ☐ Sister				
	☐ Father ☐ Mother ☐ Brother ☐ 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 AGREE to submit to a blood test and a urinalysis, including but not limited to a test to detect exposure to the agent that causes AIDS, and **I ACCEPT** that the results be disclosed to Industrial Alliance so that my insurability can be evaluated.

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 Y M D

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 Y M D

Member's signature _____ Spouse's signature _____

Signature of legal age child _____

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.

Industrial Alliance may establish a list of its insureds to share information within the Industrial Alliance Group. This will help us serve clients better and determine whether any products and services that the Industrial Alliance Group offers are suitable so we can offer such products and services to them. However, you are entitled to have your name removed from this list by making a written request to this effect to the Information Access Officer, as mentioned above.

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.