



**General information (Please print in ink)**

Policyholder's name (Employer/organization) \_\_\_\_\_  
 Group policy no. \_\_\_\_\_ Division no. \_\_\_\_\_ Class no. \_\_\_\_\_ Certificate no. \_\_\_\_\_  
 Member's last name \_\_\_\_\_ First name \_\_\_\_\_  
 Employment date | Y | M | D | Eligibility date | Y | M | D | Annual salary \$ \_\_\_\_\_

**1. Reason for completing this form**

- Applying for optional benefits
- Applying for an additional amount of insurance which exceeds the maximum amount specified by the plan:
  - Basic life  Disability Income  Critical Illness
- Plan member late enrolment in group insurance plan
- Dependents late enrolment in group insurance plan. If the spouse (and the children, if any) is or was covered under another group insurance plan, please specify the following:
  - Insurer's name \_\_\_\_\_ Group policy no. \_\_\_\_\_ Certificate no. \_\_\_\_\_
  - Date and reason of the coverage termination, if any \_\_\_\_\_
- Other, specify \_\_\_\_\_

**2. Coverage requested for the benefit(s) listed below**

**Please refer to the group insurance booklet or the plan administrator to confirm coverage amounts.**

Benefits	Current Insurance Amount	Additional Insurance Amount Requested	Total
<b>Critical Illness</b>			
1. Member	\$	\$	\$
2. Spouse	\$	\$	\$
3. Children <sup>1</sup>	\$	\$	\$
<b>Basic Life</b>			
1. Member	\$	\$	\$
2. Spouse	\$	\$	\$
3. Children <sup>1</sup>	\$	\$	\$
<b>Optional Life</b>			
1. Member	\$	\$	\$
2. Spouse	\$	\$	\$
3. Children <sup>1</sup>	\$	\$	\$
Short-term disability	\$	\$	\$
Long-term disability	\$	\$	\$
Medical	<input type="checkbox"/> Individual <input type="checkbox"/> Family <input type="checkbox"/> Single parent <input type="checkbox"/> Couple		
Dental	<input type="checkbox"/> Individual <input type="checkbox"/> Family <input type="checkbox"/> Single parent <input type="checkbox"/> Couple		

<sup>1</sup> Each child will benefit from the insurance amount you selected.



**MEDICAL STATEMENT**

Plan member: Are you actively at work and physically able to perform all work-related duties?

Yes  No. If not, explain \_\_\_\_\_

**IMPORTANT:** Questions 1 to 13 are intended for the plan member, the spouse and the dependent children, if applicable. Provide details for each affirmative answer at item 14.

	Member		Spouse		Children	
	Yes	No	Yes	No	Yes	No
1. In the last 6 months, have you been absent from work due to illness or injury?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. In the last 12 months, have you used tobacco in any form whatsoever or nicotine products (gum, patches, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. In the last five years:						
a. have you been hospitalized in a hospital or other medical institution for observation, rest, diagnosis or treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. have you 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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. other than medication prescribed by a physician, have you used barbiturates, cocaine, heroin, marijuana, opiates or other narcotics?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. have you attended a treatment program for drug abuse or were you advised to do so?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. have you been advised to stop drinking or have you attended a treatment program for alcohol abuse?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. did you submit 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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. have you requested or received benefits, compensation or an annuity due to illness or injury?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4. In the last five years, did you undergo or have you been advised to undergo one of the following tests? For each test selected, specify the date, the reason and the results at item 14 of this form (or attach the document providing this information).

	Member		Spouse		Children			Member		Spouse		Children	
	Yes	No	Yes	No	Yes	No		Yes	No	Yes	No	Yes	No
a. electrocardiogram	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	e. x-ray	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. examination for diagnostic purposes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	f. other tests	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. scan or magnetic resonance imaging	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Specify	_____	_____	_____	_____	_____	_____
d. blood tests	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		_____	_____	_____	_____	_____	_____

5. Do you currently take medication or follow a diet? (Use another sheet if needed. Date and sign any attached document.)

		If yes, please indicate the name(s) of the medication or diet.			
<b>Member</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No				
<b>Spouse</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No				
<b>Children</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	Child's first name		Answer	
		Child's first name		Answer	
		Child's first name		Answer	
		Child's first name		Answer	

6. In the past five years, have you 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 you are suffering from one of the following conditions or diseases?

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

	Member		Spouse		Children	
	Yes	No	Yes	No	Yes	No
7. Are you aware of physical or psychological disorders or abnormalities which have not been revealed in the answers given to questions 1 to 6?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Are you aware of any signs or symptoms for which a consultation and/or an examination is necessary and/or is already planned?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

9. For alcoholic beverages, tobacco and narcotics or drugs, indicate the weekly consumption. If none, indicate 0. For alcoholic beverages, 1 serving = 1 bottle of beer = 1 glass of wine = 1 ounce of alcohol.  
(For legal age children, use another sheet. Date and sign any attached document. Please indicate the first name of each child.)

	Beer	Wine	Alcohol	Tobacco	Narcotics or drugs
<b>Member</b>					
<b>Spouse</b>					

10. Do you currently or do you intend to participate in any professional or hazardous sports activity, such as scuba diving, flying an aircraft, skydiving, car racing, etc.? (Use another sheet if needed. Date and sign any attached document.)

If yes, please specify which activity and how often.			
<b>Member</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>Spouse</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>Children</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	Child's first name	Answer
		Child's first name	Answer
		Child's first name	Answer
		Child's first name	Answer

**Complete questions 11 and 12 only if you are applying for the Critical Illness Benefit.**

	Member		Spouse		Children	
	Yes	No	Yes	No	Yes	No
11. Have you experienced any history of optic neuritis, numbness, tingling, loss of balance, weakness of the extremities, visual disturbance or loss of sensation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Have any of your family members had heart disease, stroke, high blood pressure, cancer, diabetes, kidney disease, Huntington's Chorea, amyotrophic lateral sclerosis (ALS or Gehrig's disease), motor neuron disease, Multiple sclerosis, Alzheimer's disease, colon polyposis or any other hereditary disease?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

13. If you and/or your spouse answered "yes" to question 12, please complete the following table. (Use another sheet if needed. Date and sign any attached document.)

	Identify the family member	Illnesses (if cancer, please specify)	Age at the beginning of the illness	Age if living	Age at death, if applicable
<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				

14. Provide details for each affirmative answer given to questions 1 to 11  
(If more space is required, please use another sheet. Date and sign any attached document):

Question no.	First name	Reason, diagnosis, treatment, medication, surgery, if applicable, results and recommendation	Onset of illness or date of test			Period during which employment or regular duties could not be performed	Complete recovery date			Names of physicians and hospitals/clinics
			Y	M	D		Y	M	D	

**CONFIRMATION/AUTHORIZATION**

**I HEREBY CONFIRM** that the statements contained in this form and in any document attached hereto or given during a phone interview are complete and true, and **I AUTHORIZE** the release of the information to Industrial Alliance Insurance and Financial Services Inc. 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 MIB Inc., 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 children'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 children'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.

**I ALSO AUTHORIZE** Industrial Alliance and its reinsurers to make a brief report of my personal health information to MIB.

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 


 Plan member's signature **X** \_\_\_\_\_  
Spouse's signature **X** \_\_\_\_\_  
Signature(s) of legal age child(ren) **X** \_\_\_\_\_

**AUTHORIZATION**

**I AUTHORIZE** any healthcare provider or professional, medical organization, insurance or reinsurance company, the MIB Inc., 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 children's insurability, under the group plan.

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

Date 


 Plan member's signature **X** \_\_\_\_\_  
Spouse's signature **X** \_\_\_\_\_  
Signature(s) of legal age child(ren) **X** \_\_\_\_\_

**WHERE TO SUBMIT THIS FORM?**

**If you are a new plan member**, please submit this form by:

<b>Fax:</b>	1-877-392-6487	
<b>Mail:</b>	<b>Quebec</b> Administration PO Box 790, Station B Montreal, Quebec H3B 3K6	<b>All Other Provinces</b> Administration 522 University Avenue, Suite 400 Toronto, Ontario M5G 1Y7

**If you are an existing plan member**, please submit this form by:

<b>Fax:</b>	1-888-780-3486	
<b>Mail:</b>	Medical Underwriting PO Box 790, Station B Montreal, Quebec H3B 3K6	

**PRE-NOTICE FROM THE MIB INC.**

Information regarding your insurability will be treated as confidential. Industrial Alliance Insurance and Financial Services Inc. and its reinsurers may, however, make a brief report thereon to the MIB Inc., 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: MIB, 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.

**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.

**DISCLOSURE**

At Industrial Alliance, the personal information we collect concerning you and your dependents 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, Information Access Officer, 1080 Grande Allée West, PO Box 1907, Station Terminus, Quebec, 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.