

F1A **Application**



A partner you can trust.

www.inalco.com

Client(s) name(s)

TABLE OF CONTENTS

	Section	Description
Mandatory at all times	1	Proposed insured
	2	Purpose of insurance
	3	Applicant (if different than proposed insured)
	4	Other insurance
Universal Life	5	Universal Life GENESIS
	6	Confirmation of Identity
Whole life, term and mortgage insurance	7	Traditional Insurance
	8	HOME PROTECTION PLAN
Critical illness insurance	9	TRANSITION
	10	TRANSITION EVOLUTION
Supplementary income and additional benefits	11	SUPPLEMENTARY INCOME (SI)
	12	Additional benefits
Disability	13	Questionnaire for disability coverage
Mandatory at all times	14	Premiums and billing
	15	Agent
	16	Special instructions
	17	Tobacco use
	18	Risk class (for life insurance contracts or riders for \$200,000 or over)
	19	Medical requirements
	20	Predeclarations
	21	Declaration of insurability
	22	Signatures and authorization
	23	Authorizations
24	Pre-authorized cheque payments (PAC) agreement	
Give to client	25	Pre-notice from the Medical Information Bureau
Give to client if deposit	26	Interim insurance agreement in case of death or critical illness
For use by agent	27	References

Additional documents to provide (if applicable):

- Mandatory illustration for GENESIS and TRANSITION EVOLUTION
- Investor profile for GENESIS
- Q6A questionnaire for disability protection
- Q4A questionnaire for critical illness protection
- F3A form for an additional insured
- F6A or F4A form for a total or partial surrender
- Cheque to pay the first premium

1 PROPOSED INSURED (For additional insured, please complete F3A) (Write legibly in block letters.)

A Last and first name Last name _____ Last name at birth (if different) _____
 First name _____

B Address No. _____ Street _____ Apartment _____ P.O. Box _____
 City _____ Province _____ Postal Code _____

C Telephone Home phone no. _____ Work phone no. _____ Extension _____

D Date of birth and age at nearest birthday Date of birth _____ Age _____ Sex M F Save age. Language English French
 Place of birth (province or country) _____ When did you arrive in Canada? Since birth OR _____

E SIN and legal status **!** **If the SIN is not provided on the application, a copy of the proof of legal status must be submitted with the application as shown.**

Social Insurance Number (Mandatory for universal life policy)

Legal status in Canada (for people born outside Canada):
 Canadian Citizen
 Convention Refugee or Protected Person (attach proof of acceptance as refugee or protected person)
 Permanent resident (permanent resident card)
 Work permit (work permit card)
 Other _____ (letter from Citizenship and Immigration Canada confirming permanent residence application)

F Occupation (mandatory age 18 and over) Occupation _____ Since when? _____ Gross annual income _____
 M Y \$

Type of business/Educational institution (For people over age 25 attending an educational institution) _____ Net worth _____
 \$

Current employer's name and address

Previous occupation for a two-year period

From:	M	Y	To:	M	Y
From:	M	Y	To:	M	Y
From:	M	Y	To:	M	Y

2 PURPOSE OF INSURANCE

A Personal insurance Business insurance

Key person Estate freeze Buy and sell agreement
 Retirement compensation agreement (RCA) Loan Other _____

B Trial application Complete declarations of insurability, do not order any evidence
 Heart problems, diabetes, cancer, declined or postponed insurance

C Optional Other application number at Industrial Alliance _____ Additional



3 APPLICANT (if different than proposed insured)

For joint insurance, all joint insureds are applicants, unless otherwise indicated in this section below. For a Multilife application, please specify the applicant.

A Last and first name or company's name
 Last name _____
 First name _____

B Address
 No. _____ Street _____ Apartment _____ P.O. Box _____
 City _____ Province _____ Postal code _____

C Telephone
 Home phone no. _____ Work phone no. _____ Extension _____

D Date of birth and SIN
 Date of birth _____ Sex M F
 When did you arrive in Canada? _____ Social Insurance Number _____ (mandatory for universal policy)
 Place of birth _____ Relationship to proposed insured _____ Net worth \$ _____

E Occupation
 Present occupation _____ Gross annual income \$ _____ Insurance in force \$ _____

F Contingent owner _____

4 OTHER INSURANCE

A Does the proposed insured have another insurance application pending? Yes No

If yes Date _____ Year _____ Name of company _____ Amount \$ _____
 Life Critical illness Disability Ins.

this application is optional to the policies listed above Total amount to be placed \$ _____

B Has the proposed insured ever been declined or had an application modified or postponed? Yes No

If yes Reason _____
 Date _____ Year _____ Name of company _____
 Life Critical illness Disability Ins.

Reason _____
 Date _____ Year _____ Name of company _____
 Life Critical illness Disability Ins.

C Insurance in force on proposed insured None (group life and credit insurance excluded)

Industrial Alliance		Other companies		Amount of life insurance \$	Amount of critical illness insurance \$	Amount of disability insurance \$	Year of issue	Replacement/disclosure form attached
Contract no.	Will the requested insurance lead to the total or partial surrender of this policy?	Name of company	Surrender of contract					
	<input type="checkbox"/> Total surrender (F6A)* <input type="checkbox"/> Partial surrender (F4A-04)*		<input type="checkbox"/> Yes <input type="checkbox"/> No					<input type="checkbox"/>
	<input type="checkbox"/> Total surrender (F6A)* <input type="checkbox"/> Partial surrender (F4A-04)*		<input type="checkbox"/> Yes <input type="checkbox"/> No					<input type="checkbox"/>
	<input type="checkbox"/> Total surrender (F6A)* <input type="checkbox"/> Partial surrender (F4A-04)*		<input type="checkbox"/> Yes <input type="checkbox"/> No					<input type="checkbox"/>

REQUESTED COVERAGE

5 UNIVERSAL LIFE (Attention – Complete beneficiary section on page 5.)

! Joint insured(s) and/or additional insured(s) – Complete the Addition of Coverage form (F3A).

- First to die Last to die
 Last to die, paid-up on first to die

GENESIS

! For Genesis, provide the current version of the complete illustration signed by the client and the information required under the *Proceeds of Crime (Money Laundering) and Terrorist Financing Act and Regulations. (F51-208A)*

- Genesis with guaranteed interest bonus Genesis with performance bonus Genesis with low fees option
 Genesis-IRIS (with low fees option) Genesis-IRIS Plus (requires minimum first year excess premiums of \$350,000) (with low fees option)

If low fees option is elected: Without performance stabilizer With performance stabilizer
 If no instructions are provided, we will use the option without the stabilizer.

Permanent Life Coverage

\$

Term Life Coverage Rider

T10 R & C \$
 T20 R & C \$

Critical Illness Term Coverage Rider

T10 R & C \$
 T75 \$
 T100 \$

! Complete the Q4A questionnaire unless a telephone interview or paramedical is required.

Automatic Optimization of the Face Amount

- Yes No

If no instruction is given, we will use the AOFA.

Death benefit

- Face amount
 Face amount + fund
 Face amount + guaranteed return of premiums
 Face amount + fund + ACB (Available only if the policyowner is a company)
 Face amount + fund with Wealth Maximizer option
 - No reduction before years (minimum 5 years)
 - Floor face amount \$ (minimum \$1,000)

If no instructions are given, the Wealth Maximizer option is not exercised.

 Wealth Maximizer
 - No reduction before years (minimum 5 years)
 - Floor face amount \$ (minimum \$1,000)

If no instructions are given, we will apply 5 years and \$1,000.

Cost of insurance

- Annual (YRT) Levelling of the cost of insurance is planned after years. This is not an automatic option and must be requested by the applicant.

- Level

Quick payment option 10 years 15 years 20 years

- Level-Investor

! On the applicant (complete the Declaration of insurability section.)

Contribution in the event of applicant's disability (CAD) \$ /month
 or CAD = minimum premium

Contribution in the event of applicant's death (CADE) \$ /month
 or CADE = minimum premium

Contribution in the event of insured's disability (CID) \$ /month
 If the applicant is a company.

GENESIS

INVESTMENT ACCOUNTS

Automatic Investment Instructions (All) (Maximum 10; If no instructions are provided, we will use the Diversified (IA).)

Designated Deduction Account (DDA) (Maximum 10; if you want the DDA to be the same as the All at all times, do not complete this section.)

Guaranteed Interest Accounts

	%	
	All	DDA
5-year average	<input type="text"/>	<input type="text"/>
6-month term**	<input type="text"/>	<input type="text"/>
1-year term	<input type="text"/>	<input type="text"/>
2-year term*	<input type="text"/>	<input type="text"/>
3-year term*	<input type="text"/>	<input type="text"/>
4-year term*	<input type="text"/>	<input type="text"/>
5-year term*	<input type="text"/>	<input type="text"/>
10-year term*	<input type="text"/>	<input type="text"/>

Market Index Accounts

	%	
	All	DDA
Money Market	<input type="text"/>	<input type="text"/>
Bond	<input type="text"/>	<input type="text"/>
Canadian Stock	<input type="text"/>	<input type="text"/>
Global Stock	<input type="text"/>	<input type="text"/>
International Stock	<input type="text"/>	<input type="text"/>
European Stock	<input type="text"/>	<input type="text"/>
U.S. Stock	<input type="text"/>	<input type="text"/>
U.S. Stock / DAQ	<input type="text"/>	<input type="text"/>

Diversified Strategy

	%	
	All	DDA
Prudent Account	<input type="text"/>	<input type="text"/>
Moderate Account	<input type="text"/>	<input type="text"/>
Balanced Account	<input type="text"/>	<input type="text"/>
Growth Account	<input type="text"/>	<input type="text"/>
Aggressive Account	<input type="text"/>	<input type="text"/>

Active Management Accounts

	%			%			%	
	All	DDA		All	DDA		All	DDA
Canadian Stock (Dynamic)	<input type="text"/>	<input type="text"/>	International Stock (Templeton)	<input type="text"/>	<input type="text"/>	Dividend Growth (IA)	<input type="text"/>	<input type="text"/>
Canadian Stock (Fidelity)	<input type="text"/>	<input type="text"/>	Global Equity Fund (Mackenzie Cundill)	<input type="text"/>	<input type="text"/>	Global Dividend (Dynamic)	<input type="text"/>	<input type="text"/>
Canadian Stock (IA)	<input type="text"/>	<input type="text"/>	Global Stock (Oppenheimer)	<input type="text"/>	<input type="text"/>	Dividend Income (IA)	<input type="text"/>	<input type="text"/>
Canadian Stock (Leon Frazer)	<input type="text"/>	<input type="text"/>	Global Stock (Templeton)	<input type="text"/>	<input type="text"/>	NorthStar® (Fidelity)	<input type="text"/>	<input type="text"/>
Canadian Stock Small Cap (Fidelity)	<input type="text"/>	<input type="text"/>	Diversified (Fidelity)	<input type="text"/>	<input type="text"/>	Emerging Markets (Mackenzie Cundill)	<input type="text"/>	<input type="text"/>
U.S. Stock (McLean Budden)	<input type="text"/>	<input type="text"/>	Diversified (IA)	<input type="text"/>	<input type="text"/>	Canadian Bond (IA)	<input type="text"/>	<input type="text"/>
European Stock (Fidelity)	<input type="text"/>	<input type="text"/>	Global Diversified (Aston Hill)	<input type="text"/>	<input type="text"/>	Global Health Care (Renaissance)	<input type="text"/>	<input type="text"/>

Others

	%			%	
	All	DDA		All	DDA
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Industrial Alliance Insurance and Financial Services Inc. (hereafter referred to as Industrial Alliance) reserves the right to reimburse deposits at their market value if the contract is refused by the client.

*The 2 to 10 year term guaranteed interest accounts are not available in the shuttle fund. For the shuttle fund, these accounts are replaced by the 1 year guaranteed interest account.

** Available with the low fees option only.

GENESIS

BENEFICIARY – LIFE INSURANCE

Beneficiary 1 – Last and first name

Sex Date of birth % Relationship to proposed insured

M F D M Y Revocable Irrevocable

Contingent beneficiary 1

Sex
 M Revocable
 F Irrevocable

Contingent beneficiary 2

Sex
 M Revocable
 F Irrevocable

Beneficiary 2 – Last and first name

Sex Date of birth % Relationship to proposed insured

M F D M Y Revocable Irrevocable

Contingent beneficiary 1

Sex
 M Revocable
 F Irrevocable

Contingent beneficiary 2

Sex
 M Revocable
 F Irrevocable

Beneficiary 3 – Last and first name

Sex Date of birth % Relationship to proposed insured

M F D M Y Revocable Irrevocable

Contingent beneficiary 1

Sex
 M Revocable
 F Irrevocable

Contingent beneficiary 2

Sex
 M Revocable
 F Irrevocable

Trustee (if beneficiary under age 18)


Relationship to proposed insured

For beneficiary – Last and first name

For beneficiary – Last and first name

BENEFICIARY OF THE FUNDS – GENESIS

Applicant OR Beneficiary of insured no. 1 OR

 The lack of designation constitutes a revocable designation in favour of the beneficiary or beneficiaries named in the "Beneficiary – Life Insurance" section above.

Beneficiary 1 – Last and first name

Sex Date of birth % Relationship to proposed insured

M F D M Y Revocable Irrevocable

Contingent beneficiary 1

Sex
 M Revocable
 F Irrevocable

Contingent beneficiary 2

Sex
 M Revocable
 F Irrevocable

Beneficiary 2 – Last and first name

Sex Date of birth % Relationship to proposed insured

M F D M Y Revocable Irrevocable

Contingent beneficiary 1

Sex
 M Revocable
 F Irrevocable

Contingent beneficiary 2

Sex
 M Revocable
 F Irrevocable

Beneficiary 3 – Last and first name

Sex Date of birth % Relationship to proposed insured

M F D M Y Revocable Irrevocable

Contingent beneficiary 1

Sex
 M Revocable
 F Irrevocable

Contingent beneficiary 2

Sex
 M Revocable
 F Irrevocable

GENESIS

Trustee (if beneficiary under age 18)

Relationship to proposed insured

For beneficiary – Last and first name

For beneficiary – Last and first name

BENEFICIARY – CRITICAL ILLNESS

Applicant OR Insured OR

Beneficiary 1 – Last and first name

Sex Date of birth % Relationship to proposed insured

M F Revocable Irrevocable

Beneficiary 2 – Last and first name

Sex Date of birth % Relationship to proposed insured

M F Revocable Irrevocable

6 CONFIRMATION OF IDENTITY

By law, the Company is required to collect and record the following information for a non-registered annuity or universal life insurance policy.

1. COMPLETE THIS SECTION (MANDATORY)

a Information about the Applicant

This information must be collected and recorded for every Applicant. If there is more than one Applicant, this information must be collected from each one.

Name of Applicant: _____ Date of birth:

Y	M	D
---	---	---

Address (not only a P.O. Box Number): _____

Principal occupation or business (must be specific): _____

b Third Party Determination

Is the Applicant acting on someone else's instructions? No Yes (If "yes," collect the following information.)

Instructions are provided by: an individual a corporation another type of entity (please specify): _____

Name: _____ Date of birth:

Y	M	D
---	---	---

 Relationship to Applicant: _____

Address (not only a P.O. Box Number): _____

Principal occupation or business (must be specific): _____

If a corporation, provide:

Incorporation number: _____ Place of incorporation: _____

I cannot determine if the Applicant is acting on someone else's instructions, but I have reasonable grounds to suspect there is another party involved in this transaction. My reasons are:

2. COMPLETE THIS SECTION FOR EACH INDIVIDUAL APPLICANT (See section 3 for corporate applicants, partnerships, trusts, etc.)

a Verification of Identity

Refer to an original passport, driver's licence or other government-issued identification, but not a SIN card:

Type of identification document: _____ Place of issue: _____

Document number: _____ Expiry date:

Y	M	D
---	---	---

b Politically Exposed Foreign Persons (Complete if there is a lump-sum payment of \$100,000 or more.)

i. Name of Payor if different than Applicant: _____

ii. Does the Applicant or Payor, or does a relative* of the Applicant or Payor, hold, or have they ever held, any of the following senior positions in, or for, a country other than Canada:

- Head of state or head of government
- Member of the executive council of government or member of a legislature
- President of a state-owned company or state-owned bank
- Deputy Minister or equivalent
- Ambassador or attaché to ambassador
- Head of a government agency
- Military officer with rank of general or above
- Judge
- Leader of a political party represented in a legislature.

No Yes If "yes," provide name of country, position, when held, and where applicable, name of relative and relationship to Applicant or Payor:

*A relative of the Applicant or Payor means: •Their spouse or common-law partner •Their mother or father •Their brother, sister, stepbrother or stepsister •Their child •The mother or father of their spouse or common-law partner

iii. Source of funds:

If the answer to the above is "yes," describe the source of funds used for this transaction:

- Employment Income Business Income Investments Pension Loan Savings Inheritance
 Other (please explain): _____

3. COMPLETE THIS SECTION FOR CORPORATE APPLICANTS AND OTHER ENTITIES

a Information about the Applicant

Type of entity: Corporation Partnership Trust Not-for-profit organization Other (please explain): _____

Name, address, and occupation of all persons who own or control, directly or indirectly, 25 per cent or more of the shares of the corporation or 25 per cent or more of the non-corporate entity. (If the agent is unable to obtain this information, state why the information could not be obtained.)

If the Applicant is a corporation, obtain the:

Name and occupation of all directors. (If the agent is unable to obtain this information, state why the information could not be obtained.)

If the Applicant is a not-for-profit organization, answer the following:

- Is the Applicant a charity registered with the Canada Revenue Agency? Yes No
- If "no," does the Applicant solicit charitable financial donations from the public? Yes No

b Verification of Identity

You must confirm the existence of the corporation or other entity by reviewing a paper record or a public electronic document.

If you reviewed a paper record, please attach it (e.g. certificate of corporate status, partnership agreement).

If you reviewed an electronic record, provide:

Registration number: _____ Type of record: _____ Source of electronic record: _____

c Confirm the identity of the individual conducting the transaction on behalf of the corporation or non-corporate entity.

Refer to an original passport, driver's licence or other government-issued identification, but not a SIN card:

Name: _____ Date of birth:

Y	M	D
---	---	---

Address (not only a P.O. Box Number): _____

Type of identification document: _____ Document number: _____

Place of issue: _____ Expiry date:

Y	M	D
---	---	---

d Attach a copy of a document authorizing this individual to conduct this transaction on behalf of this Applicant.

4. LIFE INSURANCE AGENT'S CONFIRMATION – THIS CONFIRMATION MUST BE SIGNED AND DATED BY THE AGENT.

- As required by the Proceeds of Crime (Money Laundering) and Terrorist Financing Act and Regulations, I confirm that I have verified the identity of the Applicant by reviewing the identification documentation and I have taken reasonable measures to determine if the Applicant is acting on behalf of a third party.
- In cases where there is a lump-sum payment of \$100,000 or more for a non-registered annuity or universal life insurance policy, I confirm that I have taken reasonable measures to determine if the Applicant and the Payor (if not one and the same as the Applicant) are politically exposed foreign persons.

Agency: _____ Agency code: _____

Name of agent: _____ Agent code: _____ S.U.: _____

X

Signature of agent

Date (YYYY-MM-DD)

REQUESTED COVERAGE

7 TRADITIONAL INSURANCE (Complete beneficiary section on page 10.)

! Joint insured(s) and/or additional insured(s) – Complete the Addition of Coverage form (F3A).

- First to die Last to die
 Last to die, paid-up on first to die

Whole Life Coverage

L10 \$

L15 Ultra \$

L20 \$

L65 \$

L100 \$

T100 \$

Term Life Coverage

T10 R & C \$

T20 R & C \$

Pick-A-Term \$

Critical Illness Rider

T10 R & C \$

T75 \$

T100 \$

! Complete the Q4A questionnaire unless a telephone interview or paramedical exam is required.

Life and Serenity 65

\$

! The Q9A Preselection questionnaire must be completed.

Term

Between 10 and 40 years

Selected Option: Level

Decreasing to 50%

Decreasing to 0%
(only available for terms between 31 and 40 years)

Child Life & Health Duo

\$

! Complete the Q4A questionnaire unless a telephone interview or paramedical exam is required.

Disability Credit Rider (Please complete Disability Questionnaire in Section 13, questions a), b) and c.)

! Complete the Q6A questionnaire unless a telephone interview or paramedical exam is required.

Insurance Needs

\$ /month

As per the Needs Analysis

Benefit Chosen

\$ /month

Min. \$300, max. \$3,500 without exceeding 1.5% of the life coverage

Benefit Duration

2 years 5 years To age 65

8 HOME PROTECTION PLAN (Complete beneficiary section on next page.)

Mortgage insurance

\$

! Attach the amortization schedule or complete Q8A form. (The amortization period must not exceed 30 years.)

- Life
 Critical Illness (Complete the Q4A questionnaire unless a telephone interview or paramedical exam is required.)
 Disability 100 % Disability 50% (Maximum benefit of \$5,000 per month, see the conditions in section 13 d)

! Please complete Disability Questionnaire in Section 13.

! Complete the Q6A questionnaire unless a telephone interview or paramedical exam is required.

- 2 years or until the end of the mortgage (Maximum age 65)
 Mortgage Guaranteed Insurability (Must be subscribed by both insureds.)

TRADITIONAL INSURANCE AND HOME PROTECTION PLAN

BENEFICIARY – LIFE INSURANCE

Beneficiary 1 – Last and first name

Sex Date of birth % Relationship to proposed insured

M F D M Y Revocable Irrevocable

Contingent beneficiary 1

Sex
 M F
 Revocable
 Irrevocable

Contingent beneficiary 2

Sex
 M F
 Revocable
 Irrevocable

Beneficiary 2 – Last and first name

Sex Date of birth % Relationship to proposed insured

M F D M Y Revocable Irrevocable

Contingent beneficiary 1

Sex
 M F
 Revocable
 Irrevocable

Contingent beneficiary 2

Sex
 M F
 Revocable
 Irrevocable

Beneficiary 3 – Last and first name

Sex Date of birth % Relationship to proposed insured

M F D M Y Revocable Irrevocable

Contingent beneficiary 1

Sex
 M F
 Revocable
 Irrevocable

Contingent beneficiary 2

Sex
 M F
 Revocable
 Irrevocable

Trustee (if beneficiary under age 18)

Relationship to proposed insured

For beneficiary – Last and first name

For beneficiary – Last and first name

BENEFICIARY – CRITICAL ILLNESS

Applicant **OR** Insured **OR**

Beneficiary 1 – Last and first name

Sex Date of birth % Relationship to proposed insured

M F D M Y Revocable Irrevocable

Beneficiary 2 – Last and first name

Sex Date of birth % Relationship to proposed insured

M F D M Y Revocable Irrevocable

REQUESTED COVERAGE

9 TRANSITION (Complete beneficiary section on pages 11 and 12.)

! **Guaranteed premium critical illness product**
 Complete the Q4A questionnaire unless a telephone interview or paramedical exam is required.

T10 R & C \$ _____ T75 \$ _____ T100 \$ _____

Option 10 Option 20

Increased Benefit Rider Return of Premiums upon Death
 Flexible Return of premiums → For Transition T100, please indicate premium refund period.
 15 years 20 years 25 years

Transition Child \$ _____ **!** Complete the Addition of Coverage form F3A and Questionnaire Q4A for each child.

! **On the applicant (Complete the Declaration of Insurability section.)**

WPD is for life

10 TRANSITION – EVOLUTION T100 (Complete beneficiary section on pages 11 and 12.)

! For Transition Evolution, provide a complete illustration signed by the client.

Non guaranteed premium critical illness product
 \$ _____ **!** Complete the Q4A questionnaire unless a telephone interview or paramedical exam is required.

Riders and guarantee
 Transition Child – Evolution
 \$ _____ **!** Complete an addition of coverage form Q3A for each insured child and the Q4A questionnaire.

Increased Benefit Rider

! **On the applicant (Complete the Declaration of Insurability section.)**

WPD is for life

BENEFICIARY – CRITICAL ILLNESS

1. Benefits in the event of critical illness

Applicant or Insured or

Beneficiary 1 – Last and first name

Sex Date of birth % Relationship to proposed insured
 M Revocable
 F Irrevocable

Contingent beneficiary 1 Sex Contingent beneficiary 2 Sex
 M Revocable M Revocable
 F Irrevocable F Irrevocable

Beneficiary 2 – Last and first name

Sex Date of birth % Relationship to proposed insured
 M Revocable
 F Irrevocable

Contingent beneficiary 1 Sex Contingent beneficiary 2 Sex
 M Revocable M Revocable
 F Irrevocable F Irrevocable

Beneficiary 3 – Last and first name

Sex Date of birth % Relationship to proposed insured
 M Revocable
 F Irrevocable

Contingent beneficiary 1 Sex Contingent beneficiary 2 Sex
 M Revocable M Revocable
 F Irrevocable F Irrevocable

BENEFICIARY – CRITICAL ILLNESS (Continued)

1. Benefits in the event of critical illness (Continued)

Trustee (if beneficiary under age 18)

Relationship to proposed insured

For beneficiary – Last and first name

For beneficiary – Last and first name

2. Premium refund upon death (except Home Protection Plan)

Last and first name

Sex Date of birth % Relationship to proposed insured

 M

D

M

Y

 Revocable F Irrevocable

Last and first name

Sex Date of birth % Relationship to proposed insured

 M

D

M

Y

 Revocable F Irrevocable

3. Flexible premium refund during the insured's lifetime

Applicant or Insured

└─> Revocable Irrevocable

REQUESTED COVERAGE

11 SUPPLEMENTARY INCOME (SI)

(Available only as a rider on a life or critical illness insurance contract) **!** Please complete Disability Questionnaire in Section 13, questions a, b and c.

- a) Requested benefit • Amount of the SI benefit | \$ _____ /month |
(min. \$100, max. \$2,000 without exceeding the eligible benefit, section b)
- !** Complete the Q6A questionnaire unless a telephone interview or paramedical exam is required.
- Type of coverage Accident and illness
 Accident only → **No benefit is payable for a disability caused by an illness.**
- Duration of the benefit 2 years To age 65

b) Eligible benefit

Employment income or net business and professional income

- According to your income tax return;
- Pre-tax income (less business overhead expenses, if applicable);
- It includes bonuses if they are paid on a regular basis. It excludes interest income, rent, capital gains, retirement income and any other income that would be paid, if the insured is disabled or not.

<p>Monthly employment income or income net of business and professional income</p> <p>\$ _____ /month</p>	<p>x 70% =</p>	<p>\$ _____ /month</p>	<p>–</p>	<p>\$ _____ /month</p>	<p>=</p>	<p>\$ _____ /month</p>	
						<p>Monthly amount of group and/or individual disability insurance already in force</p>	<p>Eligible benefit</p>

! Proof of income will be required in the event of a claim. We recommend that you attach proof of income (income tax return) with the application.

12 ADDITIONAL BENEFITS

- Waiver of premiums in case of the applicant's disability (WPDIs)
- Waiver of premiums in case of the applicant's death (WPD)
- Waiver of premiums in case of the insured's disability (WP)
- Accidental fracture (AF)
- Accidental death (AD) | \$ _____
- Accidental death and dismemberment (AD&D) | \$ _____
- Guaranteed insurability (GI) | \$ _____
- Paramedical Care
- Hospitalization | \$ _____
- Hospitalization and Home Care | \$ _____

! For each child, complete the Addition of Coverage form F3A and, if critical illness is requested, questionnaire Q4A is required.

- Child module | \$ _____
- Child module PLUS | \$ _____
- Child critical illness | \$ _____

13 QUESTIONNAIRE FOR DISABILITY COVERAGE

- a) Do you work a minimum of 20 hours per week? Yes No If no → **Disability Insurance not available**
- b) Do you work a minimum of 6 months per year? Yes No If no → **Disability Insurance not available**
- c) Have you been working in your current profession for at least 1 year? Yes → Do you work a minimum of 9 months a year?
 Yes No → Are you a farmer or fisherman?
 Yes No → 2 year supplemental income accident only offered
- No → Do you practise the profession for which you studied?
 Yes No → 2 year supplemental income accident only offered
- d) Home Protection Plan Disability
- Personal residence → choice of 50% or 100%
 - Owner occupant/residential → 1 – 3 units (50% or 100%)
 4 – 6 units (50%)
 7 units (not available)
 - Non-occupant owner/residential → not available
 - Building housing a business → Occupation of 50% of the area (50% - 100%)
 Occupation of less than 50% of the area (not available)

14 PREMIUMS AND BILLING

Minimum premium (Genesis) or
Modal premium (other products)

\$ _____

Target premium (Genesis)

\$ _____

or Target premium = minimum premium

Method of payment PAC ANNUAL SEMI-ANNUAL* QUARTERLY*

*Not available with GENESIS and Transition

First premium

Deposit by cheque \$ _____

Enclose a cheque payable to Industrial Alliance

Deposit by PAC – Attach a specimen to section 24, a withdrawal will be made from the client's bank account for the amount of the minimum premium.

Do not enclose a cheque if you choose this option.

COD/PAC – Payment on delivery, amendment to be signed

No deposit will be made while the file is being reviewed.

15 AGENT

Agent Policy (spouse and children)

Last and first name _____ Code _____ SU _____ % _____

Agency _____ Code _____

Work phone no. _____ Extension _____ Cellphone no. _____

Email _____

Last and first name _____ Code _____ SU _____ % _____

Agency _____ Code _____

Work phone no. _____ Extension _____ Cellphone no. _____

Email _____

16 SPECIAL INSTRUCTIONS

17 TOBACCO USE

Have you used any kind of tobacco in the past twelve months including nicotine or tobacco products (gum, patch, etc.)?

- Yes → Smoker rate No → Non-smoker rate (answer the following question)
- Have you ever used tobacco? Yes No
- If yes, when did you quit?

M	Y				

18 RISK CLASS FOR CONTRACTS OR RIDERS FOR \$200,000 OR MORE OF LIFE INSURANCE

If preferred underwriting can be granted

- Reduce the premium
- Increase the face amount (Additional requirements may be needed.)

! If no instructions are given, the premium will be reduced.

19 MEDICAL REQUIREMENTS

Will you or your agency order medical requirements?

- No
- Yes → Name of paramedical organization _____

Order no. _____

Preferred language _____

Special instructions _____

Requirements to obtain from another company – Name of company _____

If the amount of insurance is over \$2,000,000, have you arranged for the inspection report?

- No Yes → Name of Inspection Organization _____

Special instructions _____

20 PREDECLARATIONS

1 Have you sought medical attention, been diagnosed with, received treatment for or been told you have symptoms of any of the following diseases or disorders? Yes No

If yes, specify

- | | |
|---|---|
| <input type="checkbox"/> angina/heart attack (myocardial infarction) (with or without bypass surgery/angioplasty) | <input type="checkbox"/> major depression (in the last seven years) |
| <input type="checkbox"/> cerebral vascular accident (CVA)/transient ischemic attack | <input type="checkbox"/> bipolar disorder |
| <input type="checkbox"/> chronic obstructive pulmonary disease (COPD)/chronic bronchitis/emphysema | <input type="checkbox"/> diabetes |
| <input type="checkbox"/> sleep apnea | <input type="checkbox"/> hepatitis |
| <input type="checkbox"/> Crohn's disease | <input type="checkbox"/> cancer/tumor any sites |
| <input type="checkbox"/> ulcerative colitis | <input type="checkbox"/> colon polyp |
| <input type="checkbox"/> rheumatoid arthritis | |

2 Are you being followed for another illness that requires three or more check-ups per year? Yes No

3 Physician's full name, address and phone number holding the client's file (Write legibly in block letters)

21 DECLARATION OF INSURABILITY

- Do not complete declarations of insurability in the following cases:
- Industrial Alliance holds a declaration, a telephone interview or a paramedical exam during the last six months for this insured
 - For an additional policy, requirements are generated for the total amount of insurance submitted

Proposed insured		Applicant with	
Optional if paramedical examination or phone interview required		WPDIs, WPD, CAD, CADE	
YES	NO	YES	NO

For all "Yes" answers, give details below specifying the name of the proposed insured in question.

1 Within the past five years, have you consulted a physician, chiropractor or other practitioner, undergone a medical examination or been treated in a hospital, clinic or other medical facility?

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------

If yes, provide details and answer Question 2.



Give reason and include medical history that prompted the consultation(s)
Names, addresses and phone numbers of physicians and hospitals consulted
Consultation dates (frequency)

- 2** a) Health problems or follow-up exams (nature of the problem, date of diagnosis, last date)
 b) Hospitalizations (duration)
 c) Treatment(s) received (type and duration)
 d) Medication(s) (name, dosage, duration and date last taken)
 e) Diagnostic examination(s) Electrocardiogram(s) X-Ray(s) Blood test(s) (nature, date, results)
 Other (specify) _____
 f) Follow-up examination(s) recommended (nature and date)
 g) Disability or absence from work (cause(s), date and duration)

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Details: _____

3 Have you consulted or been treated for pain or discomfort in the back, neck or joints (frequency, date, causes)?

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------

4 Have you tested positive for an AIDS screening test or for Hepatitis B or C? (specify)

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------

5 Do you have any physical or mental abnormalities? (specify)

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------

21 DECLARATION OF INSURABILITY (Continued)

	Proposed insured		Applicant with	
	Optional if paramedical examination or phone interview required		WPDIs, WPD, CAD, CADE	
	YES	NO	YES	NO
6 Do you have symptoms or signs for which you have not yet consulted a physician? (specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7 Do you take medication prescribed by a physician other than those indicated in question 2 d)? (name, dosage, reason)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8 Has any family member (father, mother, brother, sister) suffered from or is any family member suffering from diabetes, heart disease, cancer or any other hereditary disease? (Give age at diagnosis, actual age if living or age at death.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9 Have you been exposed to the AIDS virus or Hepatitis B or Hepatitis C?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10 Have you lost or gained weight by more than 10% in the last year? (If yes, specify the gain or the loss in lbs or kgs and the reason.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11 Height and weight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12 In the next two years, do you plan to travel or live for more than two months outside Canada or the U.S.? (If yes, complete the foreign residence section in Questionnaire Q1A.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Questions for insured of age 15 and over

13 During the past two years, have you taken part in any hazardous sports such as parachuting, scuba diving, bungee jumping, back-country skiing, heli-skiing, mountain climbing, hang-gliding, gliding, automobile, motorcycle or motocross racing, etc.? (If yes, complete the hazardous sports section in Questionnaire Q1A.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14 Have you made or do you intend to make aerial flights other than as a passenger? (If yes, complete the aviation section in Questionnaire Q1A.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15 Within the past five years, have you: (If one of the answers is "Yes", complete the driving record in Questionnaire Q1A.)				
a) been convicted of five infractions or more under the Highway Traffic Act?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) had your driver's license suspended or revoked? (If yes, give reason.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) been convicted or do you have any charges pending for driving while impaired? (If yes, give dates)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16 Within the past 10 years, have you used drugs, narcotics or steroids? (If yes, complete the drug section in Questionnaire in Q1A.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17 Do you or have you ever used alcohol? If yes, answer the following questions: (1 unit = 1 glass of wine = 1 bottle of beer = 1 ounce of alcohol)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
a) Current number of units and frequency:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) If there has been a reduction of alcohol consumption, enter the number of units and frequency before the reduction: (Specify date and reason.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Have you ever received treatment for alcohol use? (dates and name of physician or institution)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Have you ever been a member of a support group (such as Alcoholics Anonymous)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

22 SIGNATURES AND AUTHORIZATION

We, the proposed insured and the applicant, declare that all answers and explanations given in this application, or in any other questionnaire in connection herewith or during any interview, by telephone or otherwise, with respect to our declaration of insurability are true and complete.

We agree that the insurance takes effect as of the acceptance of the application by Industrial Alliance Insurance and Financial Services Inc. inasmuch as the latter has been accepted without modification, the first premium has been paid and no change has taken place in the insurability of the proposed insureds since the signing of the application. We acknowledge that our declaration of insurability may be completed during an interview, by telephone or otherwise, which interview may be recorded, and that Industrial Alliance will rely upon, among other things, the said declaration in determining whether to accept the application.

We hereby authorize any health care professional as well as any other public or private health or social service establishment, any insurance company, the Medical Information Bureau, financial institutions, personal information agents or professional investigation agencies and any public body holding information concerning ourselves or our family, particularly medical information, and any other public or private body holding medical or health-related information concerning ourselves or our family to supply this information to Industrial Alliance and its reinsurers for the risk assessment or the investigation necessary for the study of any claim.

We also authorize our insurer, or its reinsurers, to exchange with its subsidiaries, its underwriting service providers, and other insurers or financial institutions, the personal information obtained for the purposes of studying this application and to inquire of them for the appraisal of the risk or in the event of a claim, or to exchange with an organization offering medical assistance, personal information for relevant purposes under the insurance coverage in the event of a critical illness.

We also authorize Industrial Alliance to release any abnormal test results to our personal physician.

In case of death or disability, the beneficiary, the heir or the liquidator of my estate, is expressly authorized to supply Industrial Alliance, when required by the latter, with all information and authorizations necessary to study the death benefit or disability claim and obtain the required documentation.

We acknowledge having read the interim insurance agreement and having understood the terms thereof.

By signing below, the agent confirms that he has provided a disclosure statement to the applicant which discloses the company or companies he represents and his relationship with them; that he receives compensation (such as commissions) for the sale of insurance products and may receive other compensation such as bonuses, invitations to conferences or other incentives; and any conflicts of interest that he may have with respect to this transaction.

We agree that a photocopy of this authorization is as valid as the original.

Signed at _____ this _____ day of _____ 20____

Proposed insured (if aged 15 years and over in Quebec, if aged 16 years and over outside Quebec)	Applicant(s)/Officer's signature if a company is the applicant	If the applicant is a company, provide the names of the authorized signatories
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="text"/>

	<input checked="" type="checkbox"/>	
--	-------------------------------------	--

Agent

The applicant's signature shall be valid for all additional insureds.

⚠ The signature of one of the two parents is required for a proposed insured under age 16 if anyone other than the parents are the applicants.

23 AUTHORIZATIONS

We hereby authorize any health care professional as well as any other public or private health or social service establishment, any insurance company, the Medical Information Bureau, financial institutions, personal information agents or professional investigation agencies and any public holding information concerning ourselves or our family, particularly medical information, and any other public or private body holding medical or health-related information concerning ourselves or our family, to supply this information to Industrial Alliance and its reinsurers for the risk assessment or the investigation necessary for the study of any claim.

A photocopy of this authorization shall be as valid as the original.

Signed at _____ this _____ day of _____ 20____

Proposed insured (Quebec, age 14 and over; outside Quebec, age 16 and over) Witness

X _____ X _____

We hereby authorize any health care professional as well as any other public or private health or social service establishment, any insurance company, the Medical Information Bureau, financial institutions, personal information agents or professional investigation agencies and any public holding information concerning ourselves or our family, particularly medical information, and any other public or private body holding medical or health-related information concerning ourselves or our family, to supply this information to Industrial Alliance and its reinsurers for the risk assessment or the investigation necessary for the study of any claim.

A photocopy of this authorization shall be as valid as the original.

Signed at _____ this _____ day of _____ 20____

Proposed insured (Quebec, age 14 and over; outside Quebec, age 16 and over) Witness

X _____ X _____

24 PRE-AUTHORIZED CHEQUE PAYMENTS (PAC) AGREEMENT

Each account holder is referred to as "I" in this PAC Agreement section and makes the following statements in respect of himself or herself.

- I authorize Industrial Alliance Insurance and Financial Services Inc. (the "Company") and the financial institution designated (or any other financial institution I may authorize at any time) to begin deductions as per my instructions for regular recurring payments and/or one-time payments from time to time, for payment of all premiums, deposits, instalments and charges arising from the contract hereunder mentioned. Regular payments will be debited from my specified account based on the date and/or frequency I have chosen, whereas one-time payments from time to time can be debited from my account on any other date.
- I agree that, for the purpose of this PAC Agreement, all PACs from my account will be treated either as Personal or Business* depending on the choice I make here below.
- **I waive the right to receive pre-notification of an increase or a decrease in the amount to be debited or a change in the date and/or frequency of these payments.**
- I agree that the Company is not required to provide me with written notice of a change in a PAC amount that is made as a result of my request.
- If a PAC is dishonoured for any reason such as, but not limited to, insufficient funds ("NSF"), stop payment or account closed, the Company is authorized to re-submit the payment. **Any charges incurred by the Company as a result of the dishonoured PAC will be added to the subsequent PAC.**
- I may cancel or modify this PAC Agreement at any time, subject to providing the Company thirty (30) days notice in writing. To obtain a sample cancellation form or for more information on my right to cancel the PAC Agreement, I may contact my financial institution or visit www.cdnpay.ca concerning Rule H1 – Pre-authorized debits (PADs).
- Any cancellation of this PAC Agreement will not affect my insurance contract(s) and/or contract(s) for financial services, so long as payment is provided by an alternate method.
- **The Company will not assign this PAC Agreement without providing, any time prior to the next PAC, written notice to me of the assignment.**
- I have certain recourse rights if any PAC does not comply with this PAC Agreement. For example, I have the right to receive reimbursement for any PAC that is not authorized or is not consistent with this PAC Agreement. To obtain more information on my recourse rights, I should contact my financial institution or visit www.cdnpay.ca.

*Business PAC means a PAC for the payment of goods or services related to a business or commercial activity of the payor.

GENERAL INFORMATION

Name of Policyowner(s): _____

Contract Number: _____

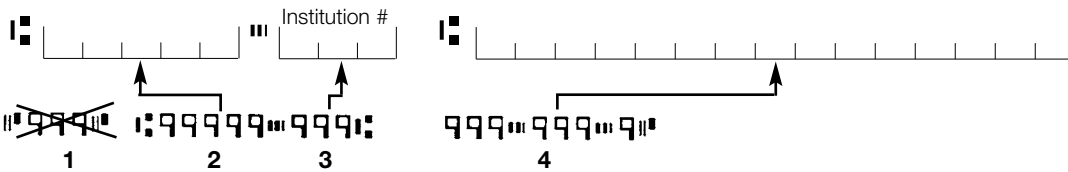
1. Do you already pay by PAC? TO HEAD OFFICE
 No → (Complete items 3 and 4 and sign.) Yes → (Complete items 2 and 4 and sign.)

2. Authorization number⁽¹⁾ _____
⁽¹⁾ The authorized signatory(ies) must always be the same as the one(s) that authorized the original transaction for which the authorization number had been issued.

3. Banking Information – Attach a personalized specimen cheque; if a specimen cheque is not attached, please complete all the banking information below.

Name of Financial Institution: _____

Name of Account holder(s): _____



- 1** This is the cheque number (do not write this number).
- 2** This is the branch number (5 digits).
- 3** This is the financial institution number (3 digits).
- 4** This is the account number. The format may vary from one financial institution to another. Indicate all numbers and only the numbers.

GENERAL INFORMATION (Continued)

4. Withdrawal Arrangement: Variable

PAC category: Personal Business (If both boxes are left unchecked, the PAC category will be considered "Personal".)

Starting

Y	Y	Y	Y	M	M	D	D

 (1st to 28th: if no date is specified, PACs will begin on the effective date of the policy)

Day of withdrawal: Day: _____ (1 to 28)
 Same as existing PAC
 Effective date

Signature (For a joint account, all required signatories must sign this PAC Agreement. For a company, the PAC Agreement must be signed by the authorized signatory(ies) and accompanied by a copy of the company's resolution stipulating the authorized signatory(ies).)

Date:

Y	Y	Y	Y	M	M	D	D

Account holder's signature

Date:

Y	Y	Y	Y	M	M	D	D

Account holder's signature, if applicable



Give to insured

25 PRE-NOTICE FROM THE MEDICAL INFORMATION BUREAU

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 (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 coverage, or a claim for benefits is submitted to such a company, the MIB, upon request, will supply such company with the information it may have in its files.

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 information in the MIB's file, you may contact the MIB and request a correction. The address of the MIB's information office is: Medical Information Bureau, 330 University Avenue, Toronto, Canada, M5G 1R7; telephone: 416 597-0590; www.mib.com.

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, it is possible that we may request additional information.

A representative from an inspection company may contact you to obtain information concerning your personal and financial status. A doctor or registered nurse from a paramedical organization may be asked to complete a medical examination and/or collect a blood or urine sample. The analysis will be used to determine the presence or absence of different abnormalities such as cholesterol, diabetes, hepatic disorders or the use of medication, drugs, nicotine, and infection by the AIDS virus.

Before collecting this blood or urine specimen, your written consent will be required.

DISCLOSURE STATEMENT

The transaction represented by this application is between the applicant and Industrial Alliance. The licensed Agent/Agency soliciting this application is an independent contractor representing Industrial Alliance and will receive compensation from Industrial Alliance when the transaction is complete. The applicant is not obligated to transact additional business with the Agent/Agency, Industrial Alliance, or any other organization as a condition of this application.

CONSTITUTION OF A FILE AND PROTECTION OF PERSONAL INFORMATION

In order to offer you insurance, annuity and credit insurance products and other complementary services according to your needs, Industrial Alliance will establish a file in which your personal information will be kept.

This file will remain strictly confidential and will be kept in Industrial Alliance's offices. Only the employees or representatives of Industrial Alliance who need this information as part of their duties, or any other person whom you authorize, will have access to this file.

You are entitled to access the personal information contained in this file and, if necessary, to have it rectified by sending a written request to the following address:

Industrial Alliance Insurance and Financial Services Inc.
Information Access Officer
1080 Grande Allée West
PO Box 1907, Station Terminus
Quebec City, QC G1K 7M3

Industrial Alliance may establish a list of its clients for its own commercial prospecting purposes or that of member companies of the Industrial Alliance group. 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 at the address indicated above.

Give to applicant if deposit made

26 INTERIM INSURANCE AGREEMENT IN CASE OF DEATH OR CRITICAL ILLNESS (Not applicable to individuals aged under 15 days or over 71 years.)

The interim insurance coverage applies to each proposed insured whose name appears on the application bearing the same number as this agreement, according to the conditions hereunder.

The Company offers insurance coverage as of the date the application bearing the same number as this agreement is signed, when an amount equal to 1/12 of the annual premium is paid with the application, including any payment made by enrolling in the PAC mode. The amount will be applied to pay for the policy on the policy issue date.

Life insurance, accidental death, accidental fracture and critical illness coverage requested on the application are payable according to the terms and exclusions of the underwritten policy and the conditions and exclusions hereunder.

MAXIMUM AMOUNT OF INSURANCE

The maximum coverage for all **interim** insurance coverages in-force for all applications signed for the same proposed insured is \$500,000 including accidental death coverage.

Policy replacement

If the requested insurance replaces a contract of the Company whose face amount is lower than the face amount of the requested insurance, the amount of the interim insurance is the difference between the requested face amount on the application and the face amount of the replaced contract.

If the requested insurance replaces a contract of the Company whose face amount is greater than or equal to the face amount of the requested insurance, no amount is payable under this interim insurance agreement.

CONDITIONS AND SPECIFIC EXCLUSIONS

This agreement does not include disability, hospitalization or paramedical care coverages and changes of insurability that occur before the date the application is accepted other than if death has occurred or a critical illness has been diagnosed.

The Interim insurance is null and void if any of the following cases applies:

- If, at the time the application is signed, the proposed insured had consulted or been treated for the illness which caused his/her death or which led to the diagnosis of a critical illness;
- If the proposed insured had consulted a physician in the 30-day period before the application was signed for a reason other than pregnancy;

- If any answer given on the application, the medical examination report or any other document or process to collect information with regards to the risk is incomplete or false and if a true answer had been given, the application would not have been accepted as requested;
- If the proposed insured is less than 15 days old or more than 71 years old on the nearest birthday when the application is signed;
- **specifically for the life insurance coverage**, if the proposed insured commits suicide, or dies:
 - while committing or attempting to commit a criminal offence;
 - after using drugs or medication otherwise than prescribed by a physician;
 - while he/she is driving a vehicle with a blood alcohol level higher than 80 milligrams per 100 millilitres of blood;
- **specifically for the critical illness coverage** if the proposed insured has already suffered from a covered critical illness or if the diagnosis of a critical is cancer or if he/she self-inflicts injuries or he/she does not survive 30 days after the date of the diagnosis.

The death benefit for the Home Protection Plan is not payable if the critical illness benefit is payable.

TERMINATION OF THE INTERIM INSURANCE AGREEMENT

The interim insurance agreement terminates on the date that the first of the following events occurs:

- The application is accepted without modification;
- 45 days after the application has been accepted with a modification such as a change of class, an extra premium, a rate change or a change in the insurance amount;
- The acceptance by the applicant of a policy issued with a modification;
- The application is denied by the Company, regardless of whether or not the applicant has been advised;
- The cancellation of the application by the applicant;
- In all cases, even though the 45-day period mentioned above has not expired, 90 days after the date the application was signed.

The death benefit and critical illness benefit are payable according to the designations made on the application and the accidental fracture benefit is payable to the applicant.

Signed at _____ this _____ day of _____ 20____

Agent

27 REFERENCES

References from the file of _____

Do you have an RRSP? No Yes Maturity date

	D			M				Y
--	---	--	--	---	--	--	--	---

Do you have a mortgage insurance? No Yes Renewal date

--	--	--	--	--	--	--	--	--	--

1 Last and first name _____ Age

--	--

 Employer _____

Spouse's last and first name _____ Age

--	--

 Children's first names _____

Address _____ Telephone

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

2 Last and first name _____ Age

--	--

 Employer _____

Spouse's last and first name _____ Age

--	--

 Children's first names _____

Address _____ Telephone

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

3 Last and first name _____ Age

--	--

 Employer _____

Spouse's last and first name _____ Age

--	--

 Children's first names _____

Address _____ Telephone

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

4 Last and first name _____ Age

--	--

 Employer _____

Spouse's last and first name _____ Age

--	--

 Children's first names _____

Address _____ Telephone

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Application

Contact Information:

Quebec:

Industrial Alliance,
Insurance and Financial Services Inc.

Customer Service
1080 Grande Allée West
PO Box 1907, Station Terminus
Quebec, Quebec G1K 7M3

Telephone: 418 684-5000
Toll-free: 1 800 463-6236
Fax: 418 684-5208
Email: clientele@inalco.com

Toronto:

Industrial Alliance,
Insurance and Financial Services Inc.

Customer Service
522 University Avenue
Toronto, Ontario M5G 1Y7

Telephone: 416 585-8862
Toll-free: 1 800 242-9751
Fax: 416 204-4777
Email: iat-clientservices@inalco.com

The elephant,
symbol of our 100 years
of strength and longevity.

