AUTHORIZATION FORM

Date: ______________________________

Dear Sir or Madam,

In order to permit us to inform your physician of the medical reasons for this decision, please return this authorization duly completed and signed.

Sincerely yours,

Underwriting Department

FULL NAME OF PHYSICIAN: ______________________________

COMPLETE ADDRESS: ______________________________

INSURANCE REQUEST CONCERNING:

NAME: ______________________________

ADDRESS: ______________________________

DATE OF BIRTH: ______________________________

FILE NUMBER: ______________________________

NAME OF AGENT: ______________________________ S.U. |__|__|

AGENCY: ______________________________

I hereby authorize Industrial Alliance Insurance and Financial Services Inc. to provide my physician with the reasons for the decision concerning my life insurance request.

______________________	______________________
Date	Signature

Please return this form to: Underwriting Department
Industrial Alliance Insurance and Financial Services Inc.
522 University Avenue
Toronto, Ontario M5G 1Y7