

F3A

Addition of coverage



A partner you can trust.

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Client(s) name(s)

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Additional documents to provide (if applicable):

- Mandatory illustration for GENESIS and TRANSITION EVOLUTION
- Q6A questionnaire for disability protection
- Q4A questionnaire for critical illness protection
- F6A or F4A form for a total or partial surrender

REQUESTED COVERAGE

4 UNIVERSAL LIFE

GENESIS ⚠ For Genesis, provide the current version of the complete illustration signed by the client.

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 exam is required.

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.

5 TRADITIONAL INSURANCE

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 10, 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

6 HOME PROTECTION PLAN

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 10 d)

! Please complete Disability Questionnaire in Section 10.

! 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.)

7 TRANSITION

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

WPDIs for life

8 SUPPLEMENTARY INCOME (SI)

(Available only as a rider on a life or critical illness insurance contract) **!** Please complete Disability Questionnaire in Section 10, 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	<ul style="list-style-type: none"> • 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.
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Monthly employment income or income net of business and professional income

Monthly amount of group and/or individual disability insurance already in force

Eligible benefit

\$ _____ /month x 70% = \$ _____ /month - \$ _____ /month = \$ _____ /month

! 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.

9 ADDITIONAL BENEFITS

- Waiver of premiums in case of the applicant's disability (WPD_{is})
- Waiver of premiums in case of the applicant's death (WPD)
- Waiver of premiums in case of the insured's disability (WP)
- 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 \$ _____

10 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)

11 BENEFICIARIES

BENEFICIARY – LIFE INSURANCE

Beneficiary 1 – Last and first name

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

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

11 BENEFICIARIES (CONTINUED)

BENEFICIARY – LIFE INSURANCE

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

Beneficiary 3 – Last and first name _____

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

Trustee (if beneficiary under age 18) _____ Relationship to proposed insured _____

For beneficiary – Last and first name _____ For beneficiary – Last and first name _____

Premium refund upon death (except Home Protection Plan)

Last and first name _____

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

Last and first name _____

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

Flexible premium refund during the insured's lifetime

Applicant or Insured
↳ Revocable Irrevocable

12 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

13 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.

14 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 _____

15 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

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

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)

16 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"/>
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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"/>
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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"/>
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5 Do you have any physical or mental abnormalities? (specify)

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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16 DECLARATION OF INSURABILITY (Continued)

	Proposed insured Optional if paramedical examination or phone interview required		Applicant with 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"/> ft	<input type="checkbox"/> cm	<input type="text"/>	<input type="text"/>
	<input type="checkbox"/> lbs	<input type="checkbox"/> kg	<input type="text"/>	<input type="text"/>
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="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	<input type="checkbox"/> Day	<input type="checkbox"/> Week	<input type="checkbox"/> Day	<input type="checkbox"/> Week
	<input type="checkbox"/> Month	<input type="checkbox"/> Year	<input type="checkbox"/> Month	<input type="checkbox"/> Year
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="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	<input type="checkbox"/> Day	<input type="checkbox"/> Week	<input type="checkbox"/> Day	<input type="checkbox"/> Week
	<input type="checkbox"/> Month	<input type="checkbox"/> Year	<input type="checkbox"/> Month	<input type="checkbox"/> Year
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"/>

17 SIGNATURES AND AUTHORIZATIONS

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 mbeen 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"/>	
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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.

18 AUTHORIZATION

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 _____

Addition of coverage

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.



INSURANCE AND FINANCIAL SERVICES INC.