Supplemental Health Questionnaire

iA Financial Group

You are being asked to complete this Questionnaire because the amount of insurance which you have applied for exceeds the amounts indicated on your Insurance Application and requires that Industrial Alliance Insurance and Financial Services Inc. ("iA Financial Group") consider additional health information. If you answer 'YES' to any of the Health Questions or the sum of your Insured Financed Amount plus Insured Residual Value for Life or CI exceeds $300,000, this Application will be underwritten.

Is the Insurance Application attached? ❑ Y ❑ N If 'No', give date Insurance Application was completed: M M D D Y Y Y Y

Tell us About Yourself. (Please Print)

APPLICANT 1 / DEBTOR – SURNAME	FIRST NAME(S)	APPLICANT 2 / CO-DEBTOR – SURNAME	FIRST NAME(S)
SEX ❑ M ❑ F / SMOKER ❑ Y ❑ N / HEIGHT ____ ❑ in ❑ cm / WEIGHT ____ ❑ lbs ❑ kg		SEX ❑ M ❑ F / SMOKER ❑ Y ❑ N / HEIGHT ____ ❑ in ❑ cm / WEIGHT ____ ❑ lbs ❑ kg	
DATE OF BIRTH M M D D Y Y Y Y	PLACE OF BIRTH (PROVINCE, STATE OR COUNTRY)	DATE OF BIRTH M M D D Y Y Y Y	PLACE OF BIRTH (PROVINCE, STATE OR COUNTRY)
OCCUPATION	TELEPHONE NUMBER ( )	OCCUPATION	TELEPHONE NUMBER ( )
APPLICATION/CERTIFICATE NO.	ADMINISTRATOR USE ONLY	APPLICATION/CERTIFICATE NO.	ADMINISTRATOR USE ONLY
NAME AND ADDRESS OF PERSONAL PHYSICIAN		NAME AND ADDRESS OF PERSONAL PHYSICIAN	
DATE AND REASON LAST CONSULTED ANY DOCTOR		DATE AND REASON LAST CONSULTED ANY DOCTOR	
DIAGNOSIS, TREATMENT AND/OR MEDICATION PRESCRIBED		DIAGNOSIS, TREATMENT AND/OR MEDICATION PRESCRIBED	

HEALTH QUESTIONS	Applicant 1 Debtor YES	Applicant 1 Debtor NO	Applicant 2 Co-Debtor YES	Applicant 2 Co-Debtor NO	**Particulars of 'Yes' Answers** *with dates, duration, type of disease, disorder or injury and names and addresses of all doctors, hospitals, etc.*
For Life, Critical Illness and/or Disability Insurance:					***If you require more space, please attach a separate sheet of paper, signed and dated.***
1. Have you ever attended a medical facility, consulted a physician, been diagnosed with, taken prescribed medication or been treated for: • Coronary artery disease, chest pain, heart attack, murmur or other condition related to the heart or circulatory system, high blood pressure, diabetes, blood disorder, stroke or transient ischemic attack (TIA), cancer or tumour, a positive HIV test or any other auto-immune disorder including AIDS, hepatitis or other liver disorder, abnormal electrocardiogram (ECG), abnormal mammogram or PAP smear, disease or disorder of the breast, prostate or bladder?	❑	❑	❑	❑	
2. Within the past 24 months have you attended a medical facility, consulted a physician, been diagnosed with, taken prescribed medication or been treated for: • Shortness of breath, asthma, emphysema or other lung or respiratory disorders, systemic lupus, rheumatoid arthritis, disorder of the reproductive organs, kidney disease, ulcerative colitis, Crohns' disease or other disorders of the stomach or pancreas, seizures, paralysis, Multiple Sclerosis or other disorders of the nervous system, stress, anxiety, depression or any other mental or psychiatric disorder, alcohol or drug abuse?	❑	❑	❑	❑	
3. Have you ever applied for any insurance which was declined, modified or rated?	❑	❑	❑	❑	
For Critical Illness Insurance Only:					
4. Have any of your natural parents, brothers or sisters ever suffered from any of the following conditions: heart disease, stroke, high blood pressure, diabetes, cancer or tumor, systemic lupus, multiple sclerosis, motor neurone disease including Amyotrophic Lateral Sclerosis (ALS), polycystic kidney disease or any inherited disease? Please provide the relationship of the family member (mother, father, sister, brother), and the nature of the disease including their age when diagnosed.	❑	❑	❑	❑	
For Disability Insurance Only:					
5. Within the past 24 months have you: a) Been partially or totally disabled and/or received disability or Worker's Compensation benefits?	❑	❑	❑	❑	
b) Consulted a physician or other health care professional, been diagnosed with, taken prescribed medication or been treated for: fibromyalgia, fibrositis, osteoarthritis, chronic fatigue syndrome, strains or other disorders of the back, neck, shoulder, elbows, knees, hips or other joints, muscles, ligaments or tendons?	❑	❑	❑	❑	

Here's the Fine Print. Please give us Your Authorization. (Please Read, Sign and Date)

I acknowledge receipt of the Disclosure Notice describing the operation of the Medical Information Bureau. I authorize:

i) any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau, or other organization, institution or person, that has any records or knowledge of me or my health, to give to iA Financial Group or their reinsurers any such information. A copy of this authorization shall be as valid as the original.

ii) iA Financial Group to test and evaluate a specimen of my blood, urine or saliva for the purpose of assessing me as an insurance risk. This analysis includes testing for HIV infection.

iii) iA Financial Group to release any abnormal test results to my personal physician.

I understand that this Questionnaire may be completed during an interview, by telephone or otherwise, which may be recorded, and that iA Financial Group will rely upon, among other things, my answers in determining whether to approve coverage provided. It is further understood and agreed that;

1. **full coverage will not be in effect until my Application, this Questionnaire and any other medical information provided is approved by iA Financial Group, the full premium is paid and there has been no change in my insurability between the date of this application and the Effective Date of Insurance;**
2. **any coverage arising from this Application may be voidable if there is any incorrect answer or misrepresentation in the Application or Questionnaire; and**
3. **It is my responsibility to notify iA Financial Group of any changes in health, insurability or occupation prior to the Effective Date of Insurance.**

I confirm that the foregoing answers, forming part of an Application for group insurance to iA Financial Group, are true, complete and correctly recorded.

X _____ APPLICANT 1 – DEBTOR _____ DATE (MM/DD/YYYY)

X _____ APPLICANT 2 – CO-DEBTOR _____ DATE (MM/DD/YYYY)

FORM C7194E (JUN/2019)

Detach Here

Supplemental Health Questionnaire

Disclosure Notice – Medical Information Bureau

Please Read Carefully and Keep With Your Records

Information regarding your insurability will be treated as confidential. Industrial Alliance Insurance and Financial Services Inc. or its reinsurers may, however, make a brief report to the Medical Information Bureau, a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to a member company, the Bureau, upon request, will supply that company with the information in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction. The address of the Bureau's Information office is 330 University Avenue, Suite 102, Toronto, Ontario, Canada M5G 1R7, telephone number (416) 597-0590.

iA Financial Group or its reinsurers may also release information in the file to other life insurance companies to whom you apply for life or health insurance, or to whom a claim for benefits is submitted.

Request for Further Information

As part of our procedure to assess your eligibility for insurance you may receive a telephone call from a member of our staff. This interview, if required, will be of short duration and will take place at a time convenient to you. If you are not available when we call, we will try and arrange that you return our call at no expense to you.

This information will be held in strictest confidence. Inquiries concerning this notice should be directed to the Underwriting Department of iA Financial Group.

Underwritten by:

Industrial Alliance Insurance and Financial Services Inc., P.O. Box 5900, Vancouver, BC, V6B 5H6, **(604) 737-9374, 1-800-663-9498**