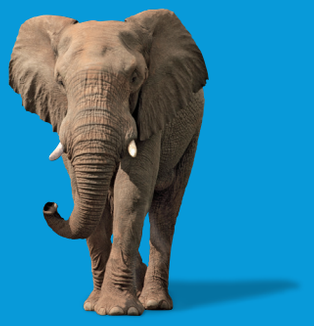
GROUP INSURANCE

Administration Guide

A partner you can trust



INDUSTRIAL ALLIANCE
INSURANCE AND FINANCIAL SERVICES

Administration Guide

Industrial Alliance has developed this guide to facilitate the administration of your group insurance plan. It describes the procedures that should be followed in the day-to-day administration of your plan.

If you require more information, please contact one of our Customer Service Representatives:

Customer Service

Phone numbers

Toll-free: 1-877-422-6487 (1-877-IA-ANGUS)
Toronto region: 416-585-8921
Montreal region: 514-499-3800

Fax numbers

Toll-free: 1-877-392-6487 (1-877-FX-ANGUS)
Toronto region: 416-204-4779
Montreal region: 514-499-3784

Mailing Address (according to your administrative centre)

Toronto

Administration or Disability Claims Department
522 University Avenue, Suite 400
Toronto, Ontario M5G 1Y7

Fax numbers
Administration: 1-888-781-0924
Disability Claims: 1-877-781-1583

Health & Dental Claims Department
PO Box 4643, Station A
Toronto, Ontario M5W 5E3
Fax: 1-877-780-7247

Montreal

Administration or Disability Claims Department
PO Box 790, Station B
Montreal, Quebec H3B 3K6

Fax numbers
Administration: 1-888-780-2376
Disability Claims: 1-877-799-6691

Health & Dental Claims Department
PO Box 800, Station Maison de la Poste
Montreal, Quebec H3B 3K5
Fax: 1-855-884-9811

Website

ia.ca

Email Address

groupinsurance@ia.ca

Thank you for choosing Industrial Alliance Group Insurance

We offer financial protection to companies of all sizes and in all types of business. To this end, we focus on the quality of our service and a solid partnership with our representatives.

With two administrative centres in Montreal and Toronto, and regional sales and service offices across Canada, Industrial Alliance provides clients with personalized service attuned to the regional characteristics of each market.

To ensure that we always provide quality service, we regularly measure our clients' degree of satisfaction.

At Industrial Alliance Group Insurance, we offer you and your team products and services adapted to your needs.

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Forms, Communiqués, Infobulletins and Other Useful Documents

You can easily download and print forms, communiqués, infobulletins and other useful documents directly from our website!

Our website also allows you to find useful information, including the billing calendar, information regarding prescription drug cost management and information regarding fraud prevention.

Our website allows you to connect to My Client Space, our secure website, for the online administration of your plan and to access your personal group insurance plan online.

This guide is available in PDF format on our website.

❯ Premium Statement

An Administrative Tool

Your monthly premium statement is made up of three documents: an in-force list of participants, a list of changes and adjustments and the premium notice.

Changes received prior to the 15th of the month will appear on the next premium statement.

IN-FORCE LIST OF PARTICIPANTS

For each plan member, the list indicates the member's name, insurance benefits, type of protection (individual or family), insurance volumes, class, contractual premium amount (generally monthly), and sales tax.

CHANGES AND ADJUSTMENTS

This document contains any changes received before the 15th of the month that result in a debit or credit. If the change results in a credit, it will appear as a negative amount on the list of changes and adjustments. Adjustments are pro-rated according to the number of days of insurance (1/30 daily).

PREMIUM NOTICE

The premium notice shows the summary of volume of insurance and the number of plan members by benefit in your plan. It also summarizes the amounts received, the amounts invoiced and the total premium to be paid. You will receive two copies of the premium notice: one to retain in your files and the other to be returned with your cheque payment, if applicable.

Industrial Alliance offers you three options for paying your monthly premium: pre-authorized withdrawals (PAW), Internet or cheque. If you opt for the Internet or cheque payment methods, premiums are due on the first day of the month after your statement is generated. If you opt for the pre-authorized withdrawal payment method, premiums will automatically be withdrawn from your bank account on the date you selected on the *Policyholder Pre-Authorized Withdrawals* (PAW) form (F54-863A).

If the entire premium for your group insurance policy is not received by the end of the allocated period, you will receive a letter reminding you that your premium payment is overdue. If the entire payment has still not been received within 45 days of the due date, health and dental claim reimbursements for all plan members under the group insurance policy will be suspended.

Premium Statement

INDUSTRIAL ALLIANCE
INSURANCE AND FINANCIAL SERVICES INC.

GROUP INSURANCE

POLICY NO: 99999 DIVISION NO: 00001

ABC ENTERPRISES INC.
MS. CONNIE SMITH
299 MY STREET.
KINGSTON, ONTARIO
M2R 2B7

IN-FORCE LIST OF PARTICIPANTS

PAGE: 1
IF

PERIOD FROM 2014-01-01 THROUGH 2014-01-31
ISSUE DATE 2014-01-01

AGENT: B11111 REP: 12

PARTICIPANT	CERTIFICATE	CLASS	INCOME FREQUENCY	BASIC LIFE	BASIC AND OPTIONAL AD&D	OPTIONAL LIFE	HEALTH INSURANCE	DENTAL CARE	SHORT-TERM DISABILITY	LONG-TERM DISABILITY	OTHER BENEFITS	TAX	TOTAL (INCL. TAX)
BROWN KIM	123 456 789 EMP	100	25 000A										
	DEP												
TOSTLER ROBERT	321 789 456 EMP	100	20 000A										
	DEP												

In-force List of Participants

INDUSTRIAL ALLIANCE
INSURANCE AND FINANCIAL SERVICES INC.

GROUP INSURANCE

POLICY NO: 99999 DIVISION NO: 00001

ABC ENTERPRISES INC.
MS. CONNIE SMITH
299 MY STREET.
KINGSTON, ONTARIO
M2R 2B7

CHANGES AND ADJUSTMENTS

PAGE: 1
CA

PERIOD FROM 2014-01-01 THROUGH 2014-01-31
ISSUE DATE 2014-01-01

AGENT: B11111 REP: 12

PARTICIPANT	CERTIFICATE	CLASS	CODE EFFECTIVE DATE	BASIC LIFE	BASIC AND OPTIONAL AD&D	OPTIONAL LIFE	HEALTH INSURANCE	DENTAL CARE	SHORT-TERM DISABILITY	LONG-TERM DISABILITY	OTHER BENEFITS	TAX	TOTAL (INCL. TAX)
BROWN KIM	123 456 789	100	01-20030105	5.44-	1.00-		19.10-		6.33-	18.65-		4.55-	55.07-
TOSTLER ROBERT	321 789 456	100	01-20030105	6.80-	1.25-		19.10-		8.03-	23.66-		5.29-	64.13-

Changes and Adjustments

INDUSTRIAL ALLIANCE
INSURANCE AND FINANCIAL SERVICES INC.

GROUP INSURANCE

POLICY NO: 99999 DIVISION NO: 00001

ABC ENTERPRISES INC.
MS. CONNIE SMITH
299 MY STREET.
KINGSTON, ONTARIO
M2R 2B7

PREMIUM NOTICE

PAGE: 1
PN

PERIOD FROM 2014-01-01 THROUGH 2014-01-31
ISSUE DATE 2014-01-01

AGENT: B11111 REP: 12

IN-FORCE	BASIC LIFE	BASIC AND OPTIONAL AD&D	OPTIONAL LIFE	HEALTH INSURANCE	DENTAL CARE	SHORT-TERM DISABILITY	LONG-TERM DISABILITY	OTHER BENEFITS	TOTAL
NUMBER OF PARTICIPANTS	0	0	0	0	0	0	0	0	
VOLUME									
MODAL PREMIUM									
ADJUSTMENT	480.38-	84.15-		1149.09-		424.58-	1260.88-		3,399.08-

Premium Notice

1 - NEW PLAN MEMBER

All new plan members must join the group insurance plan if they meet the following conditions:

- They meet the definition of eligible plan member as specified in your group insurance policy;
- They have completed the eligibility waiting period described in your group insurance policy;
- They are in a class of plan member that is eligible for coverage.

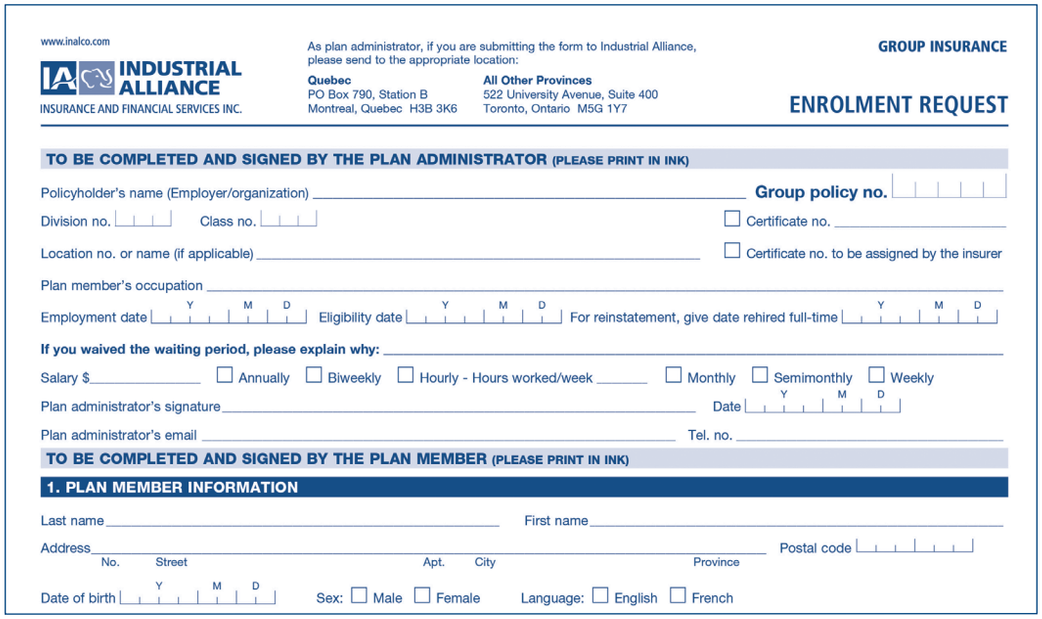
Enrolment Request

You and the eligible plan member must complete and sign in ink the *Enrolment Request* form (F54-018A).

If you use Web@dmin to enrol a plan member, please perform the enrolment within 31 days of the eligibility date for the group insurance plan and keep the form for your records.

If you do not use Web@dmin, please submit a copy of the form to one of our offices within 31 days of the plan member's eligibility date and make sure to keep the original form in your files.

For a waiver of benefits, see section 6 on page 12 of this guide.



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INDUSTRIAL ALLIANCE
INSURANCE AND FINANCIAL SERVICES INC.

As plan administrator, if you are submitting the form to Industrial Alliance, please send to the appropriate location:

Quebec
PO Box 790, Station B
Montreal, Quebec H3B 3K6

All Other Provinces
522 University Avenue, Suite 400
Toronto, Ontario M5G 1Y7

GROUP INSURANCE

ENROLMENT REQUEST

TO BE COMPLETED AND SIGNED BY THE PLAN ADMINISTRATOR (PLEASE PRINT IN INK)

Policyholder's name (Employer/organization) _____ **Group policy no.** [ ]

Division no. [ ] Class no. [ ] ☐ Certificate no. _____

Location no. or name (if applicable) _____ ☐ Certificate no. to be assigned by the insurer

Plan member's occupation _____

Employment date [Y M D] Eligibility date [Y M D] For reinstatement, give date rehired full-time [Y M D]

If you waived the waiting period, please explain why: _____

Salary $_____ ☐ Annually ☐ Biweekly ☐ Hourly - Hours worked/week _____ ☐ Monthly ☐ Semimonthly ☐ Weekly

Plan administrator's signature _____ Date [Y M D]

Plan administrator's email _____ Tel. no. _____

TO BE COMPLETED AND SIGNED BY THE PLAN MEMBER (PLEASE PRINT IN INK)

1. PLAN MEMBER INFORMATION

Last name _____ First name _____

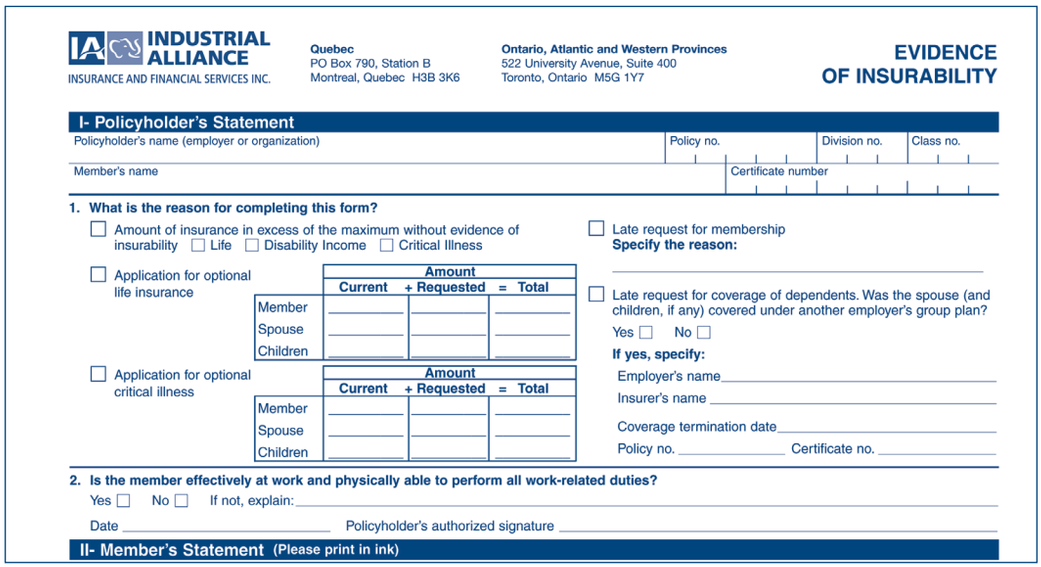
Address _____ Postal code [ ]
No. Street Apt. City Province

Date of birth [Y M D] Sex: ☐ Male ☐ Female Language: ☐ English ☐ French

F54-018A

Evidence of Insurability

If the *Enrolment Request* form is submitted more than 31 days after the eligibility date, evidence of insurability may be required. If so, attach the completed and signed in ink *Evidence of Insurability* form (F54-002A) to the *Enrolment Request* form (F54-018A).



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PO Box 790, Station B
Montreal, Quebec H3B 3K6

Ontario, Atlantic and Western Provinces
522 University Avenue, Suite 400
Toronto, Ontario M5G 1Y7

EVIDENCE OF INSURABILITY

I- Policyholder's Statement

Policyholder's name (employer or organization) | Policy no. | Division no. | Class no.

Member's name | Certificate number

1. What is the reason for completing this form?

☐ Amount of insurance in excess of the maximum without evidence of insurability ☐ Life ☐ Disability Income ☐ Critical Illness

☐ Application for optional life insurance

	Amount		
	Current	+ Requested	= Total
Member			
Spouse			
Children			

☐ Application for optional critical illness

	Amount		
	Current	+ Requested	= Total
Member			
Spouse			
Children			

☐ Late request for membership
Specify the reason:

☐ Late request for coverage of dependents. Was the spouse (and children, if any) covered under another employer's group plan?
Yes ☐ No ☐
If yes, specify:
Employer's name
Insurer's name
Coverage termination date
Policy no. Certificate no.

2. Is the member effectively at work and physically able to perform all work-related duties?
Yes ☐ No ☐ If not, explain:

Date Policyholder's authorized signature

II- Member's Statement (Please print in ink)

F54-002A

2 - CHANGE OF COVERAGE

2.1. Individual to Family

A plan member with individual coverage can request family coverage if he/she has eligible dependents. You and the eligible plan member must complete and sign in ink the *Change Request* form (F54-070A) within 31 days after one of the following events:

- Marriage or civil union
- Permanent cohabitation with a common-law spouse during the period stipulated in your group insurance policy (generally 1 year)
- Termination of the spouse's group insurance
- Birth or adoption of a first child

Please indicate any change in class on the form, if applicable.

If you use Web@dmin to process a change of coverage and other modifications, please perform them within 31 days of the event and keep the form for your records.

If you do not use Web@dmin, please submit a copy of the form to one of our offices within 31 days of the event and retain the original form for your files.

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INSURANCE AND FINANCIAL SERVICES INC.

As plan administrator, if you use Web@dmin to process the changes, please keep this form for your files. If you do not use Web@dmin, please send the form to the appropriate address:

Quebec
PO Box 790, Station B
Montreal, Quebec H3B 3K6

All Other Provinces
522 University Avenue, Suite 400
Toronto, Ontario M5G 1Y7

GROUP INSURANCE

CHANGE REQUEST

TO BE COMPLETED AND SIGNED BY THE PLAN ADMINISTRATOR (PLEASE PRINT IN INK)

Policyholder's name (Employer/organization) **Group policy no.**

Division no. Class no. Certificate no.

Location no. or name (if applicable)

Plan member's name (as shown on our records)

Plan administrator's signature Date Y M D

Plan administrator's email Tel. no.

TO BE COMPLETED AND SIGNED BY THE PLAN MEMBER (PLEASE PRINT IN INK)

1. CHANGE OF NAME OR ADDRESS

New last name New first name

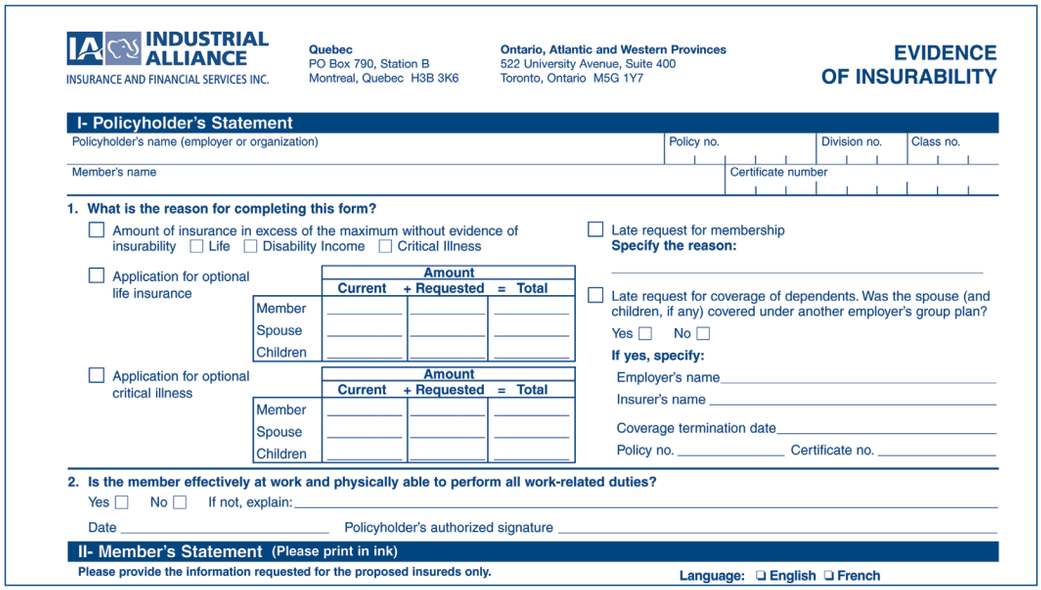
New address Postal code
No. Street Apt. City Province

Effective date of address change (if applicable) Y M D Email

F54-070A

Evidence of Insurability

If a dependent is not added to the plan within 31 days of the effective date of the dependent's eligibility, evidence of insurability may be required. Attach the completed and signed in ink *Evidence of Insurability* form (F54-002A) to the *Change Request* form (F54-070A).



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PO Box 790, Station B
Montreal, Quebec H3B 3K6

Ontario, Atlantic and Western Provinces
522 University Avenue, Suite 400
Toronto, Ontario M5G 1Y7

EVIDENCE OF INSURABILITY

I- Policyholder's Statement

Policyholder's name (employer or organization) | Policy no. | Division no. | Class no.

Member's name | Certificate number

1. What is the reason for completing this form?

☐ Amount of insurance in excess of the maximum without evidence of insurability ☐ Life ☐ Disability Income ☐ Critical Illness

☐ Application for optional life insurance

	Amount Current	+ Requested	= Total
Member			
Spouse			
Children			

☐ Application for optional critical illness

	Amount Current	+ Requested	= Total
Member			
Spouse			
Children			

☐ Late request for membership
Specify the reason:

☐ Late request for coverage of dependents. Was the spouse (and children, if any) covered under another employer's group plan?
Yes ☐ No ☐
If yes, specify:
Employer's name
Insurer's name
Coverage termination date
Policy no. Certificate no.

2. Is the member effectively at work and physically able to perform all work-related duties?
Yes ☐ No ☐ If not, explain:

Date Policyholder's authorized signature

II- Member's Statement (Please print in ink)
Please provide the information requested for the proposed insureds only.
Language: ❑ English ❑ French

F54-002A

2.2. Family to Individual

A plan member with family coverage can request individual coverage if the family coverage is no longer required. The *Change Request* form (F54-070A) must be completed and signed in ink and the reason for the change indicated. **The change will be effective from the date that the plan member's status changed if the request is received within 31 days following the change.**

If you use Web@dmin to process the change, please keep the form for your records. If you do not use Web@dmin, submit a copy of the form to Industrial Alliance and retain the original.

2.3. New Spouse

Even if the plan member is insured for family coverage, the plan member must submit the name of the new spouse within 31 days of his/her marriage, civil union or the end of the cohabitation period stipulated in your group insurance policy.

The plan member must complete and sign in ink the *Change Request* form (F54-070A).

If you use Web@dmin to add a spouse and modify the coverage, please keep the form for your records. If you do not use Web@dmin, submit a copy of the form to Industrial Alliance and retain the original.

If a spouse is not added to the plan within 31 days of the marriage, civil union or end of the cohabitation period stipulated in your group insurance policy, evidence of insurability may be required. Attach the completed and signed in ink *Evidence of Insurability* form (F54-002A) to the *Change Request* form (F54-070A).

2.4. New Dependent Child

To add a dependent child, the plan member must submit the name of the dependent child within 31 days of his/her birth or adoption date.

The plan member must complete and sign in ink the *Change Request* form (F54-070A).

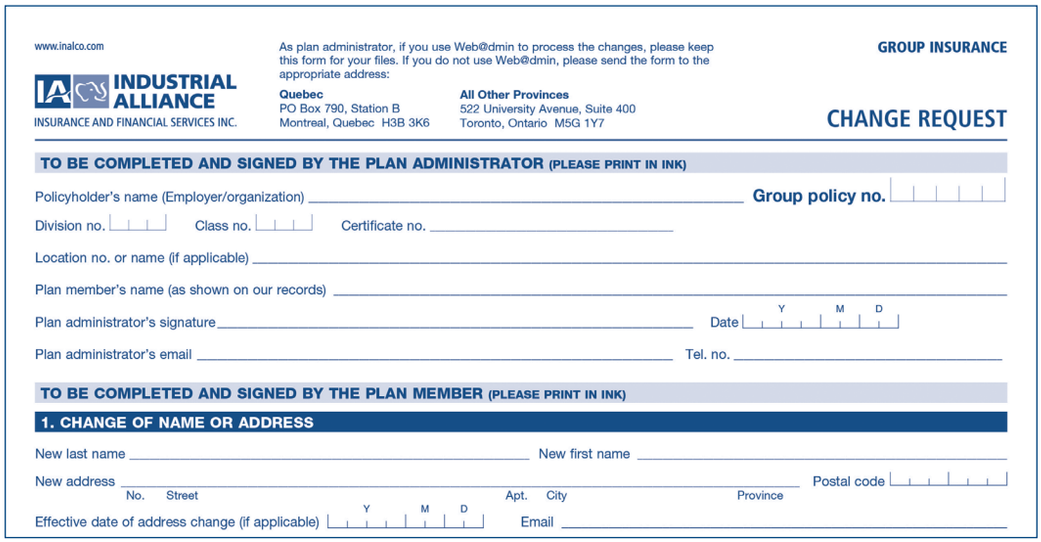
If you use Web@dmin to add a child and modify the coverage, please keep the form for your records. If you do not use Web@dmin, submit a copy of the form to Industrial Alliance and retain the original.

If a dependent child is not added to the plan within 31 days of his/her birth or adoption date, evidence of insurability may be required. Attach the completed and signed in ink *Evidence of Insurability* form (F54-002A) to the *Change Request* form (F54-070A).

3 - CHANGE OF NAME OR ADDRESS

3.1. Change of Name

Complete the *Change Request* form (F54-070A) specifying the new name and have the plan member sign the form in ink. Please attach a copy of an official document (e.g. health card, marriage certificate, etc.) as proof.



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INSURANCE AND FINANCIAL SERVICES INC.

As plan administrator, if you use Web@dmin to process the changes, please keep this form for your files. If you do not use Web@dmin, please send the form to the appropriate address:

Quebec
PO Box 790, Station B
Montreal, Quebec H3B 3K6

All Other Provinces
522 University Avenue, Suite 400
Toronto, Ontario M5G 1Y7

GROUP INSURANCE

CHANGE REQUEST

TO BE COMPLETED AND SIGNED BY THE PLAN ADMINISTRATOR (PLEASE PRINT IN INK)

Policyholder's name (Employer/organization) _____ **Group policy no.** _____

Division no. ___ Class no. ___ Certificate no. _____

Location no. or name (if applicable) _____

Plan member's name (as shown on our records) _____

Plan administrator's signature _____ Date Y M D

Plan administrator's email _____ Tel. no. _____

TO BE COMPLETED AND SIGNED BY THE PLAN MEMBER (PLEASE PRINT IN INK)

1. CHANGE OF NAME OR ADDRESS

New last name _____ New first name _____

New address _____ Postal code _____
No. Street Apt. City Province

Effective date of address change (if applicable) Y M D Email _____

F54-070A

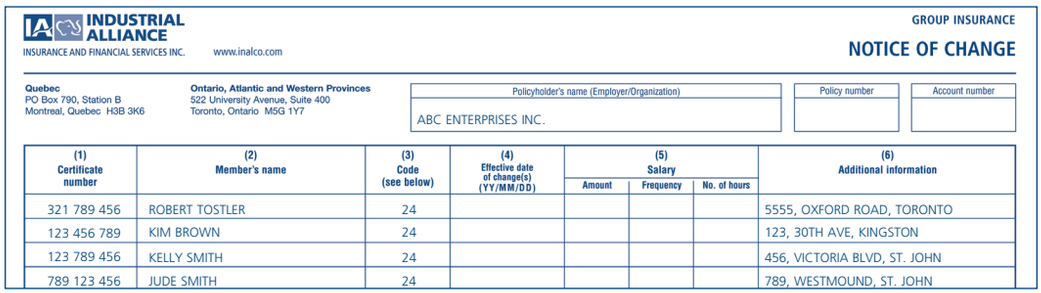
3.2. Change of Address

To make a change of address along with other modifications to a plan member's file, complete the *Change Request* form (F54-070A), specifying the new address and other modifications, and have the plan member sign the form in ink.

If you use Web@dmin to process the changes, please keep the form for your records. If you do not use Web@dmin, submit a copy of the form to Industrial Alliance and retain the original.

For a simple change of address, you can process it in one of the two following ways:

- Via Web@dmin, if you have transactional access to Web@dmin; or
- By completing the *Notice of Change* form (F54-020A), indicating code 24 and the new address(es), including postal code.



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GROUP INSURANCE

NOTICE OF CHANGE

Quebec
PO Box 790, Station B
Montreal, Quebec H3B 3K6

Ontario, Atlantic and Western Provinces
522 University Avenue, Suite 400
Toronto, Ontario M5G 1Y7

Policyholder's name (Employer/Organization): ABC ENTERPRISES INC.

Policy number:

Account number:

(1) Certificate number	(2) Member's name	(3) Code (see below)	(4) Effective date of change(s) (YY/MM/DD)	(5) Salary			(6) Additional information
				Amount	Frequency	No. of hours	
321 789 456	ROBERT TOSTLER	24					5555, OXFORD ROAD, TORONTO
123 456 789	KIM BROWN	24					123, 30TH AVE, KINGSTON
123 789 456	KELLY SMITH	24					456, VICTORIA BLVD, ST. JOHN
789 123 456	JUDE SMITH	24					789, WESTMOUND, ST. JOHN

F54-020A

4 - APPOINTMENT OR CHANGE OF BENEFICIARY

To appoint, change or revoke a plan member's beneficiary or change a beneficiary's status (revocable/irrevocable), have the plan member complete and sign in ink:

- The *Appointment or Change of Beneficiary* form (F54-887A); or
- The "Appointment or Change of Beneficiary" section of the *Change Request* form (F54-070A).

According to the law, the beneficiary designation is only valid if no prior irrevocable beneficiary designation exists. If the status of the beneficiary previously designated is irrevocable, refer to the "Revoking a Beneficiary" section below to learn about the legal provisions that apply.

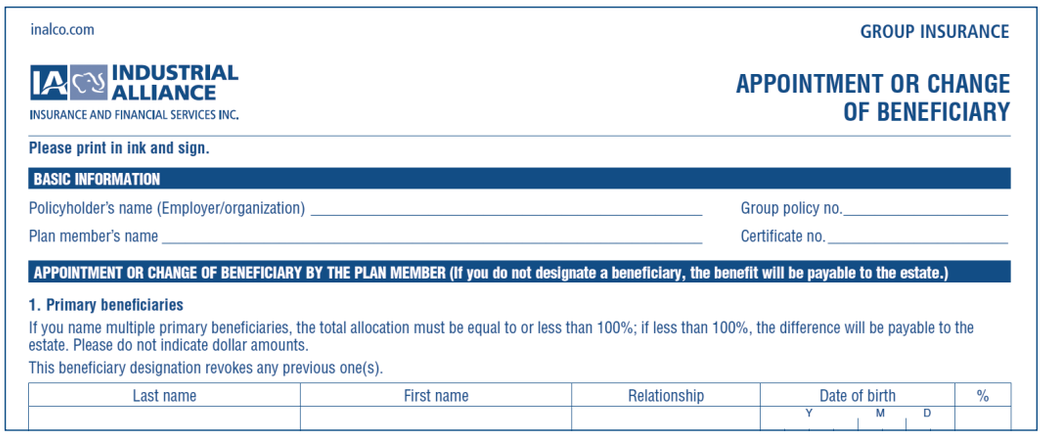
Revoking a Beneficiary

- Minors designated as irrevocable beneficiaries cannot renounce their beneficiary rights.
- If the designation replaces a deceased irrevocable beneficiary, provide proof of death.
- If the designation replaces an irrevocable beneficiary following a divorce, provide proof of divorce.
- In all other cases, the irrevocable beneficiary's signature must be obtained.

Reminder Regarding Beneficiary Appointments

- Sections for the beneficiary appointment, the signature and the date must be completed in ink.
- The plan member cannot appoint himself/herself as a beneficiary.
- If the beneficiary appointment has been crossed out or altered with correction fluid or tape, the plan member must initial the change.
- The total allocation must be equal to or less than 100% (if less than 100%, the balance will be payable to the estate).
- In Quebec, if the plan member does not indicate that the designation of his/her spouse is revocable, the designation is considered irrevocable.

It is important for you to retain the originals of the appointment or change of beneficiary forms as you may have to provide them to Industrial Alliance upon request.



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GROUP INSURANCE

INDUSTRIAL ALLIANCE
INSURANCE AND FINANCIAL SERVICES INC.

APPOINTMENT OR CHANGE OF BENEFICIARY

Please print in ink and sign.

BASIC INFORMATION

Policyholder's name (Employer/organization) _____ Group policy no. _____

Plan member's name _____ Certificate no. _____

APPOINTMENT OR CHANGE OF BENEFICIARY BY THE PLAN MEMBER (If you do not designate a beneficiary, the benefit will be payable to the estate.)

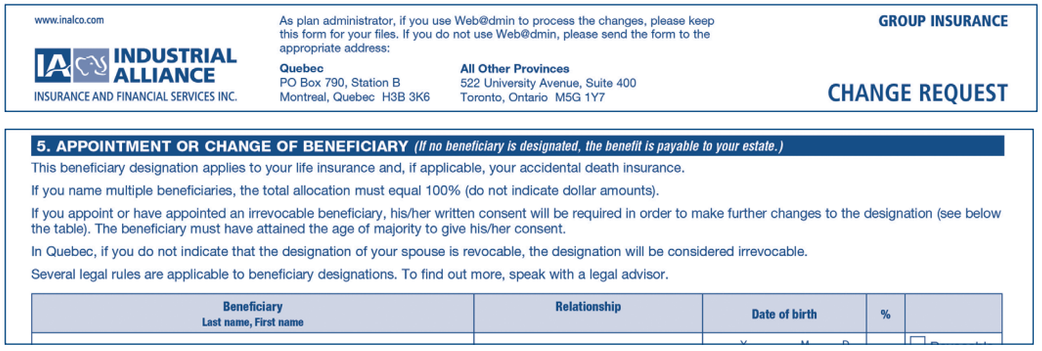
1. Primary beneficiaries

If you name multiple primary beneficiaries, the total allocation must be equal to or less than 100%; if less than 100%, the difference will be payable to the estate. Please do not indicate dollar amounts.

This beneficiary designation revokes any previous one(s).

Last name	First name	Relationship	Date of birth	%
			Y M D	

F54-887A



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INDUSTRIAL ALLIANCE
INSURANCE AND FINANCIAL SERVICES INC.

As plan administrator, if you use Web@dmin to process the changes, please keep this form for your files. If you do not use Web@dmin, please send the form to the appropriate address:

Quebec
PO Box 790, Station B
Montreal, Quebec H3B 3K6

All Other Provinces
522 University Avenue, Suite 400
Toronto, Ontario M5G 1Y7

GROUP INSURANCE

CHANGE REQUEST

5. APPOINTMENT OR CHANGE OF BENEFICIARY *(If no beneficiary is designated, the benefit is payable to your estate.)*

This beneficiary designation applies to your life insurance and, if applicable, your accidental death insurance.

If you name multiple beneficiaries, the total allocation must equal 100% (do not indicate dollar amounts).

If you appoint or have appointed an irrevocable beneficiary, his/her written consent will be required in order to make further changes to the designation (see below the table). The beneficiary must have attained the age of majority to give his/her consent.

In Quebec, if you do not indicate that the designation of your spouse is revocable, the designation will be considered irrevocable.

Several legal rules are applicable to beneficiary designations. To find out more, speak with a legal advisor.

Beneficiary Last name, First name	Relationship	Date of birth	%	
		Y M D		

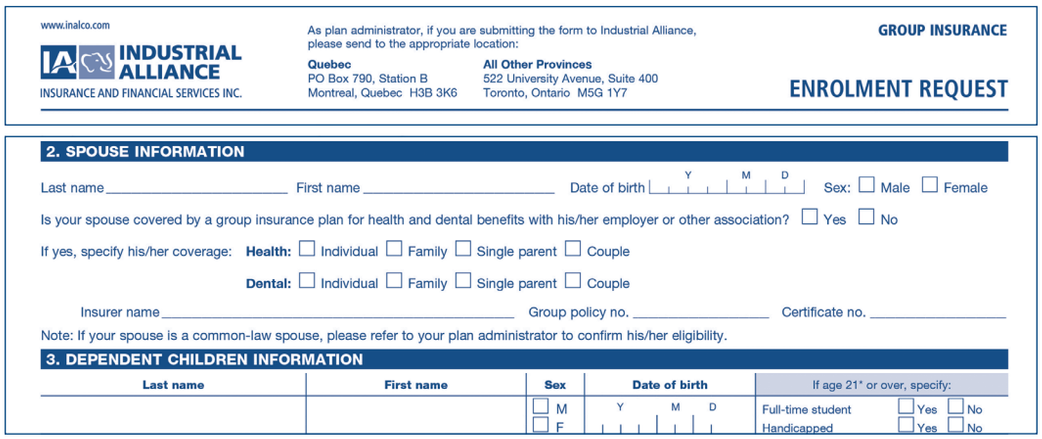
F54-070A

5 - COORDINATION OF BENEFITS

If a plan member or dependent is covered by another group insurance plan, they can also be covered by your group insurance policy to maximize reimbursement (see the Canadian Life and Health Insurance Association Inc. (CLHIA) guide). When coordination of benefits applies, the plan member must complete and check the appropriate boxes in:

- The *Enrolment Request* form (F54-018A), under the "Spouse Information" section and the "Dependent Children Information" section; or
- The *Change Request* form (F54-070A), under the "Change of Coverage" section.

Please submit a copy of the form to Industrial Alliance and retain the original.



www.inalco.com

INDUSTRIAL ALLIANCE
INSURANCE AND FINANCIAL SERVICES INC.

As plan administrator, if you are submitting the form to Industrial Alliance, please send to the appropriate location:

Quebec
PO Box 790, Station B
Montreal, Quebec H3B 3K6

All Other Provinces
522 University Avenue, Suite 400
Toronto, Ontario M5G 1Y7

GROUP INSURANCE

ENROLMENT REQUEST

2. SPOUSE INFORMATION

Last name _____ First name _____ Date of birth Y M D Sex: ☐ Male ☐ Female

Is your spouse covered by a group insurance plan for health and dental benefits with his/her employer or other association? ☐ Yes ☐ No

If yes, specify his/her coverage: **Health:** ☐ Individual ☐ Family ☐ Single parent ☐ Couple

Dental: ☐ Individual ☐ Family ☐ Single parent ☐ Couple

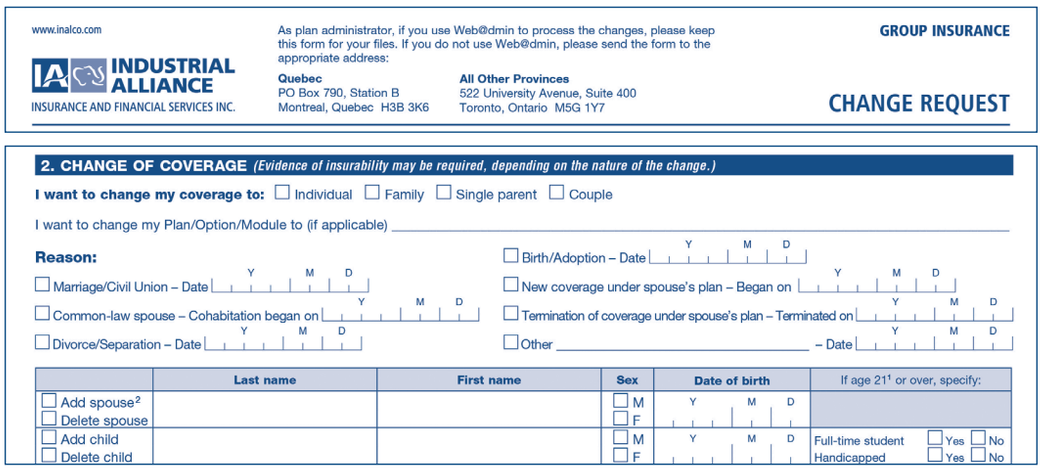
Insurer name _____ Group policy no. _____ Certificate no. _____

Note: If your spouse is a common-law spouse, please refer to your plan administrator to confirm his/her eligibility.

3. DEPENDENT CHILDREN INFORMATION

Last name	First name	Sex	Date of birth	If age 21* or over, specify:
		☐ M ☐ F	Y M D	Full-time student ☐ Yes ☐ No Handicapped ☐ Yes ☐ No

F54-018A



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INDUSTRIAL ALLIANCE
INSURANCE AND FINANCIAL SERVICES INC.

As plan administrator, if you use Web@dmin to process the changes, please keep this form for your files. If you do not use Web@dmin, please send the form to the appropriate address:

Quebec
PO Box 790, Station B
Montreal, Quebec H3B 3K6

All Other Provinces
522 University Avenue, Suite 400
Toronto, Ontario M5G 1Y7

GROUP INSURANCE

CHANGE REQUEST

2. CHANGE OF COVERAGE ***(Evidence of insurability may be required, depending on the nature of the change.)***

I want to change my coverage to: ☐ Individual ☐ Family ☐ Single parent ☐ Couple

I want to change my Plan/Option/Module to (if applicable) _____

Reason:

☐ Marriage/Civil Union – Date Y M D
☐ Common-law spouse – Cohabitation began on Y M D
☐ Divorce/Separation – Date Y M D
☐ Birth/Adoption – Date Y M D
☐ New coverage under spouse's plan – Began on Y M D
☐ Termination of coverage under spouse's plan – Terminated on Y M D
☐ Other _____ – Date Y M D

	Last name	First name	Sex	Date of birth	If age 21[1] or over, specify:
☐ Add spouse[2] ☐ Delete spouse			☐ M ☐ F	Y M D	
☐ Add child ☐ Delete child			☐ M ☐ F	Y M D	Full-time student ☐ Yes ☐ No Handicapped ☐ Yes ☐ No

F54-070A

6 - WAIVER (CANCELLATION) OF BENEFITS

A plan member insured as a dependent on his/her spouse's group insurance plan can waive the Health Insurance and/or Dental Care benefits under your group insurance policy. The plan member must complete and check the appropriate boxes in:

- The *Enrolment Request* form (F54-018A), under the "Spouse Information" section and the "Waiver of Benefits" section; or
- The *Change Request* form (F54-070A), under the "Change of Coverage" section and under the "Waiver of Benefits" section.

If you use Web@dmin to waive the plan member's health and dental benefits, please keep the form for your records. If you do not use Web@dmin, submit a copy of the form to Industrial Alliance and retain the original.

7 - REINSTATEMENT OF BENEFITS

If the spouse's group coverage has been terminated (job loss or group insurance termination), the plan member may request the reinstatement of Health Insurance and/or Dental Care benefits.

You and the eligible plan member must complete and sign in ink the *Change Request* form (F54-070A).

If you use Web@dmin, please perform the reinstatement within 31 days of the date of the spouse's group coverage termination and keep the form for your records.

If you do not use Web@dmin, please submit a copy of the form to one of our offices within 31 days of the date of the spouse's group coverage termination and make sure to keep the original form in your files.

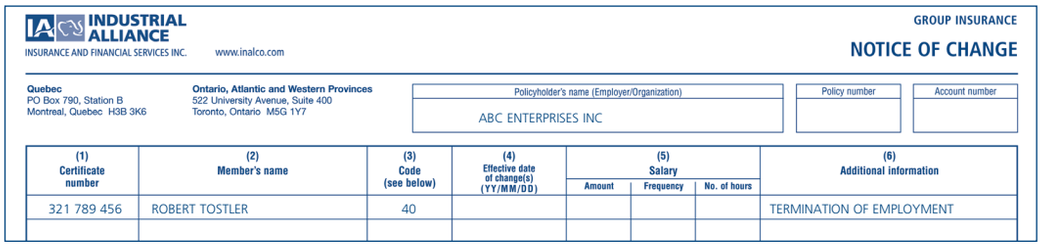
If the reinstatement is requested more than 31 days after the date of the spouse's group coverage termination, evidence of insurability may be required. If so, attach the completed and signed in ink *Evidence of Insurability* form (F54-002A) to the *Change Request* form (F54-070A).

8 - TERMINATION OF EMPLOYMENT

8.1. Employment Terminated (cancellation of insurance)

Following a termination of employment, you can terminate the plan member's and his/her dependents' coverage in one of two ways:

- Via Web@dmin, if you have transactional access to Web@dmin; or
- By completing the *Notice of Change* form (F54-020A), indicating code 40 and the last day of work.



INDUSTRIAL ALLIANCE
INSURANCE AND FINANCIAL SERVICES INC. www.inalco.com

GROUP INSURANCE

NOTICE OF CHANGE

Quebec
PO Box 790, Station B
Montreal, Quebec H3B 3K6

Ontario, Atlantic and Western Provinces
522 University Avenue, Suite 400
Toronto, Ontario M5G 1Y7

Policyholder's name (Employer/Organization): ABC ENTERPRISES INC

Policy number:

Account number:

(1) Certificate number	(2) Member's name	(3) Code (see below)	(4) Effective date of change(s) (YY/MM/DD)	(5) Salary			(6) Additional information
				Amount	Frequency	No. of hours	
321 789 456	ROBERT TOSTLER	40					TERMINATION OF EMPLOYMENT

F54-020A

8.2. Conversion of Group Life Insurance to an Individual Policy

Basic and/or Optional Life coverage of a plan member or of his/her dependents may be converted to an Individual Policy at termination of employment, subject to the conversion privilege.

The Life coverage can be converted **only if applied for within 31 days of the date the coverage is terminated**. Make sure the plan member or spouse is aware of this time limit.

How does it work?

1. Determine whether the conversion privilege is applicable under the terms of the *Plan Member's Life Insurance Benefit* and the *Dependents' Life Insurance Benefit* provisions in your group insurance policy.
2. Have the plan member or spouse complete and sign in ink a *Request for Conversion – Group Life Insurance to Individual Life Insurance* form (F54-030A) if the conversion privilege is applicable.
3. Have the plan member mail the completed form to the specified address on the form.

8.3. Conversion of Group Medical and Dental Insurance to an Individual Policy

A plan member's Group Medical and Dental coverage may be converted to an Individual Policy at termination of employment, subject to the conversion privilege.

The medical and dental coverage can be converted **only if applied for within 60 days of the date the coverage is terminated**. Make sure the plan member is aware of this time limit.

How does it work?

1. Determine whether the conversion privilege is applicable under the terms of the *Medical and Dental Insurance Benefit* provision.
2. Have the plan member complete and sign in ink an *Individual Health Insurance Application – TRANSIT* form (F54-776A-2) if the conversion privilege is applicable.
3. Have the plan member mail the completed form to the specified address on the form.

8.4. Temporary Layoff

Indicate code 43 on the *Notice of Change* form (F54-020A).

Note: Refer to the *Termination of Insurance* section in your group insurance policy to learn more about the specific stipulations regarding this clause.

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GROUP INSURANCE
NOTICE OF CHANGE

Quebec
PO Box 790, Station B
Montreal, Quebec H3B 3K6

Ontario, Atlantic and Western Provinces
522 University Avenue, Suite 400
Toronto, Ontario M5G 1Y7

Policyholder's name (Employer/Organization): ABC ENTERPRISES INC.
Policy number:
Account number:

(1) Certificate number	(2) Member's name	(3) Code (see below)	(4) Effective date of change(s) (YY/MM/DD)	(5) Salary			(6) Additional information
				Amount	Frequency	No. of hours	
321 789 456	ROBERT TOSTLER	31					

F54-020A

9 - RETURN TO WORK

Refer to the *Reinstatement of Insurance* section of your group insurance policy to establish if the duration of the absence allows a reinstatement of coverage or if you need to enrol the plan member as a new one.

9.1. Return to Work Following Termination or Temporary Layoff

- If the duration of the absence was shorter than the period in your group insurance policy for which coverage can be reinstated without an eligibility period, you can process it in one of two ways:
  - Via Web@dmin, if you have transactional access to Web@dmin; or
  - By completing the *Notice of Change* form (F54-020A), indicating code 31.
- If the duration of the absence was longer than the period stipulated in your group insurance policy, follow the same procedure specified in section 1 of this guide, "New Plan Member".

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GROUP INSURANCE
NOTICE OF CHANGE

Quebec
PO Box 790, Station B
Montreal, Quebec H3B 3K6

Ontario, Atlantic and Western Provinces
522 University Avenue, Suite 400
Toronto, Ontario M5G 1Y7

Policyholder's name (Employer/Organization): ABC ENTERPRISES INC.
Policy number:
Account number:

(1) Certificate number	(2) Member's name	(3) Code (see below)	(4) Effective date of change(s) (YY/MM/DD)	(5) Salary			(6) Additional information
				Amount	Frequency	No. of hours	
321 789 456	ROBERT TOSTLER	31					

F54-020A

9.2. Return from an Absence Caused by Disability

Complete the *Notice of Return to Work* form (F54-268A), specifying the type of return (gradual, part-time or full-time) and the number of hours worked per week.

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INSURANCE AND FINANCIAL SERVICES INC.

GROUP INSURANCE
NOTICE OF RETURN TO WORK

According to you region, please submit completed form to:

Quebec
PO Box 800, Station Maison de la Poste
Montreal, Quebec H3B 3K5

Ontario, Atlantic and Western Provinces
522 University Avenue, Suite 400
Toronto, Ontario M5G 1Y7

Last and first name of member (print in ink)
Policy Number
Div.
No.
Street
Apartment
Certificate Number
City
Postal Code
Name of policyholder (employer)

F54-268A

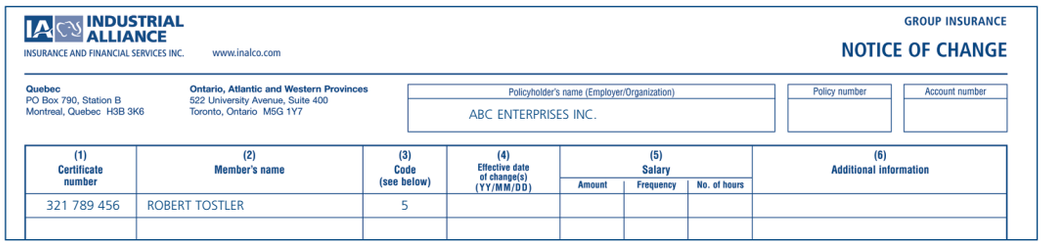
10 - SALARY CHANGE

You can process a salary change or a mass salary change in one of two ways:

- Via Web@dmin, if you have transactional access to Web@dmin; or
- By completing the *Notice of Change* form (F54-020A), indicating code 5.

Please perform the transaction in Web@dmin or submit the form to one of our offices within 31 days of the date of the salary change. Past the 31-day period, the salary change will be effective on the date the request is received.

As plan administrator, you must inform us of any salary changes as soon as possible. Failure to properly report salary increases will result in benefit payments to your plan members being lower than they should be.



INDUSTRIAL ALLIANCE
INSURANCE AND FINANCIAL SERVICES INC. www.inalco.com

GROUP INSURANCE
NOTICE OF CHANGE

Quebec
PO Box 790, Station B
Montreal, Quebec H3B 3K6

Ontario, Atlantic and Western Provinces
522 University Avenue, Suite 400
Toronto, Ontario M5G 1Y7

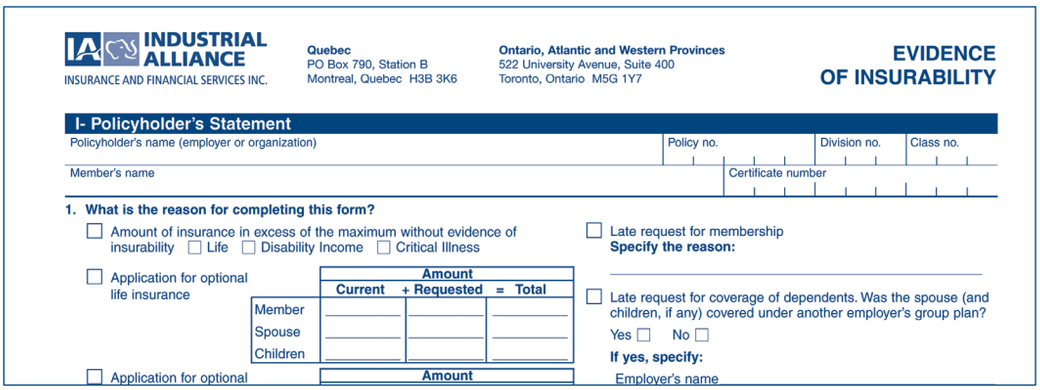
Policyholder's name (Employer/Organization): ABC ENTERPRISES INC.
Policy number:
Account number:

(1) Certificate number	(2) Member's name	(3) Code (see below)	(4) Effective date of change(s) (YY/MM/DD)	(5) Salary			(6) Additional information
				Amount	Frequency	No. of hours	
321 789 456	ROBERT TOSTLER	5					

F54-020A

Evidence of Insurability

If the salary increase exceeds the maximum available without evidence of insurability stipulated in your group insurance policy, attach the completed and signed in ink *Evidence of Insurability* form (F54-002A) to the *Notice of Change* form (F54-020A).



INDUSTRIAL ALLIANCE
INSURANCE AND FINANCIAL SERVICES INC.

Quebec
PO Box 790, Station B
Montreal, Quebec H3B 3K6

Ontario, Atlantic and Western Provinces
522 University Avenue, Suite 400
Toronto, Ontario M5G 1Y7

EVIDENCE OF INSURABILITY

I- Policyholder's Statement

Policyholder's name (employer or organization) | Policy no. | Division no. | Class no.

Member's name | Certificate number

1. What is the reason for completing this form?

☐ Amount of insurance in excess of the maximum without evidence of insurability ☐ Life ☐ Disability Income ☐ Critical Illness

☐ Application for optional life insurance

	Amount		
	Current	+ Requested	= Total
Member			
Spouse			
Children			

☐ Application for optional — Amount

☐ Late request for membership
Specify the reason:

☐ Late request for coverage of dependents. Was the spouse (and children, if any) covered under another employer's group plan?
Yes ☐ No ☐
If yes, specify:
Employer's name

F54-002A

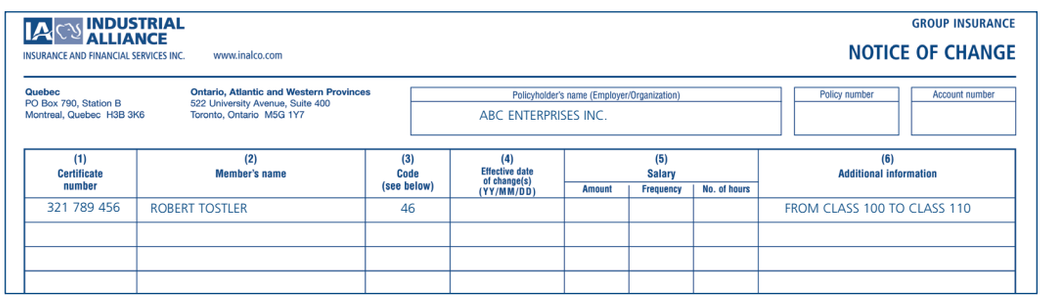
11 - CHANGE IN CLASS

The plan member's coverage depends on the class to which he/she belongs. If your group insurance policy allows for several classes, please advise us of any change in class.

You can process a class change in one of two ways:

- Via Web@dmin, if you have transactional access to Web@dmin; or
- By completing the *Notice of Change* form (F54-020A), indicating code 46 and the new class.

Please perform the transaction in Web@dmin or submit the form to one of our offices within 31 days of the date of the change. Past the 31-day period, the change in class will be effective on the date the request is received.



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INSURANCE AND FINANCIAL SERVICES INC. www.inalco.com

GROUP INSURANCE
NOTICE OF CHANGE

Quebec
PO Box 790, Station B
Montreal, Quebec H3B 3K6

Ontario, Atlantic and Western Provinces
522 University Avenue, Suite 400
Toronto, Ontario M5G 1Y7

Policyholder's name (Employer/Organization): ABC ENTERPRISES INC.
Policy number:
Account number:

(1) Certificate number	(2) Member's name	(3) Code (see below)	(4) Effective date of change(s) (YY/MM/DD)	(5) Salary			(6) Additional information
				Amount	Frequency	No. of hours	
321 789 456	ROBERT TOSTLER	46					FROM CLASS 100 TO CLASS 110

F54-020A

12 - TRANSFER OF DIVISION

You can process a division change in one of two ways:

- Via Web@dmin, if you have transactional access to Web@dmin; or
- By completing the *Notice of Change* form (F54-020A), indicating code 45, the names of the plan members who have transferred from one division to another and any change in class, if applicable.

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GROUP INSURANCE
NOTICE OF CHANGE

Quebec
PO Box 790, Station B
Montreal, Quebec H3B 3K6

Ontario, Atlantic and Western Provinces
522 University Avenue, Suite 400
Toronto, Ontario M5G 1Y7

Policyholder's name (Employer/Organization): ABC ENTERPRISES INC.
Policy number:
Account number:

(1) Certificate number	(2) Member's name	(3) Code (see below)	(4) Effective date of change(s) (YY/MM/DD)	(5) Salary			(6) Additional information
				Amount	Frequency	No. of hours	
321 789 456	ROBERT TOSTLER	45					FROM CLASS 100 TO CLASS 110

F54-020A

13 - LEAVE OF ABSENCE

Please note that only the benefits specified in your group insurance policy for each leave of absence will remain effective.

13.1. Maternity Leave, Parental Leave

Before the departure date, complete the *Notice of Change* form (F54-020A), specifying:

- Code 75
- The date of departure on leave
- The expected delivery date, if applicable
- The expected date of return

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INSURANCE AND FINANCIAL SERVICES INC. www.inalco.com

GROUP INSURANCE
NOTICE OF CHANGE

Quebec
PO Box 790, Station B
Montreal, Quebec H3B 3K6

Ontario, Atlantic and Western Provinces
522 University Avenue, Suite 400
Toronto, Ontario M5G 1Y7

Policyholder's name (Employer/Organization): LES ENTREPRISES ABC INC.
Policy number:
Account number:

(1) Certificate number	(2) Member's name	(3) Code (see below)	(4) Effective date of change(s) (YY/MM/DD)	(5) Salary			(6) Additional information
				Amount	Frequency	No. of hours	
123 456 789	KIM BROWN	75					MATERNITY LEAVE DEPARURE DATE
123 456 789	KIM BROWN	75					EXPECTED DELIVERY DATE
123 456 789	KIM BROWN	75					EXPECTED RETURN DATE

F54-020A

13.2. Other Leave of Absence (Except Temporary Layoff – see section 8.4. on page 14 of this guide)

Before the departure date, complete the *Notice of Change* form (F54-020A), specifying:

- The code according to the nature of the absence
- The date of departure on leave
- The expected date of return

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GROUP INSURANCE
NOTICE OF CHANGE

Quebec
PO Box 790, Station B
Montreal, Quebec H3B 3K6

Ontario, Atlantic and Western Provinces
522 University Avenue, Suite 400
Toronto, Ontario M5G 1Y7

Policyholder's name (Employer/Organization):
Policy number:
Account number:

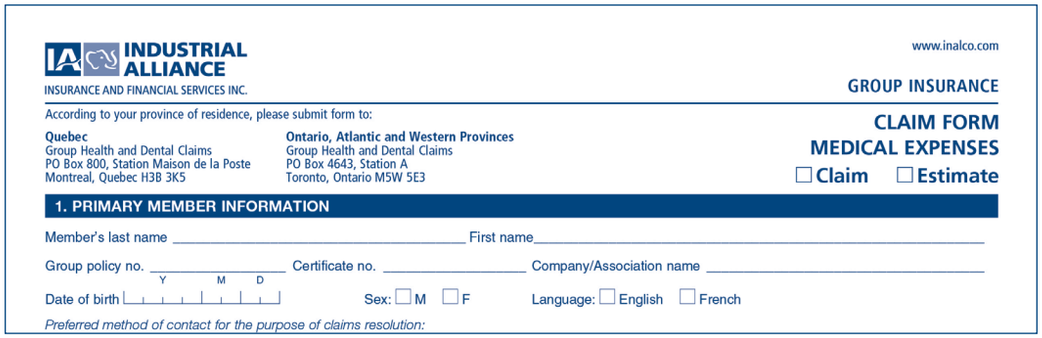
(1) Certificate number	(2) Member's name	(3) Code (see below)	(4) Effective date of change(s) (YY/MM/DD)	(5) Salary			(6) Additional information
				Amount	Frequency	No. of hours	
123 789 456	KELLY SMITH	X					UNPAID LEAVE DEPARTURE DATE
123 789 456	KELLY SMITH	X					UNPAID LEAVE RETURN DATE

F54-020A

1 - SUPPLEMENTAL HEALTH INSURANCE

1.1. Medical Expenses

To request a reimbursement for prescription drugs, medical expenses, paramedical care, vision care or ambulance fees, the plan member must complete the *Medical Expenses* form (F54-326A) and attach the original receipts.



INDUSTRIAL ALLIANCE
INSURANCE AND FINANCIAL SERVICES INC.

www.inalco.com

GROUP INSURANCE

According to your province of residence, please submit form to:

Quebec
Group Health and Dental Claims
PO Box 800, Station Maison de la Poste
Montreal, Quebec H3B 3K5

Ontario, Atlantic and Western Provinces
Group Health and Dental Claims
PO Box 4643, Station A
Toronto, Ontario M5W 5E3

CLAIM FORM
MEDICAL EXPENSES
☐ Claim ☐ Estimate

1. PRIMARY MEMBER INFORMATION

Member's last name _____ First name _____

Group policy no. _____ Certificate no. _____ Company/Association name _____

Date of birth Y M D Sex: ☐ M ☐ F Language: ☐ English ☐ French

Preferred method of contact for the purpose of claims resolution:

F54-326A

Group Benefit Card

If your plan includes a group benefit card, claims will be electronically transmitted under the condition that the plan member presents his/her group benefit card to the pharmacist.

Original Receipts

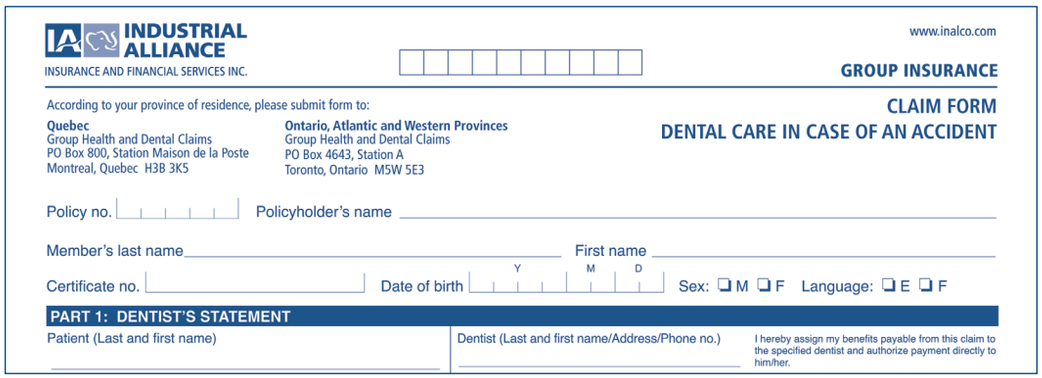
In some cases, original receipts may be requested. Receipts are not returned to the insured.

- To coordinate benefits with another insurer, the plan member must include a duplicate or photocopy of the receipts, along with a copy of the benefits statement issued by Industrial Alliance.
- The plan member may use the benefits statements or the benefit history report available on CyberClient for income tax purposes.

1.2. Dental Care in Case of Accident

Expenses incurred for dental care related to an accidental injury will be covered if they meet the requirements under your supplemental health insurance benefit.

To request a reimbursement for Dental Care following accidental injury to natural teeth, the plan member must submit the completed and signed in ink *Dental Care in Case of an Accident* form (F54-267A) and attach the x-rays taken after the accident but before the treatment.



INDUSTRIAL ALLIANCE
INSURANCE AND FINANCIAL SERVICES INC.

www.inalco.com

GROUP INSURANCE

According to your province of residence, please submit form to:

Quebec
Group Health and Dental Claims
PO Box 800, Station Maison de la Poste
Montreal, Quebec H3B 3K5

Ontario, Atlantic and Western Provinces
Group Health and Dental Claims
PO Box 4643, Station A
Toronto, Ontario M5W 5E3

CLAIM FORM
DENTAL CARE IN CASE OF AN ACCIDENT

Policy no. _____ Policyholder's name _____

Member's last name _____ First name _____

Certificate no. _____ Date of birth Y M D Sex: ❑ M ❑ F Language: ❑ E ❑ F

PART 1: DENTIST'S STATEMENT

Patient (Last and first name)

Dentist (Last and first name/Address/Phone no.)

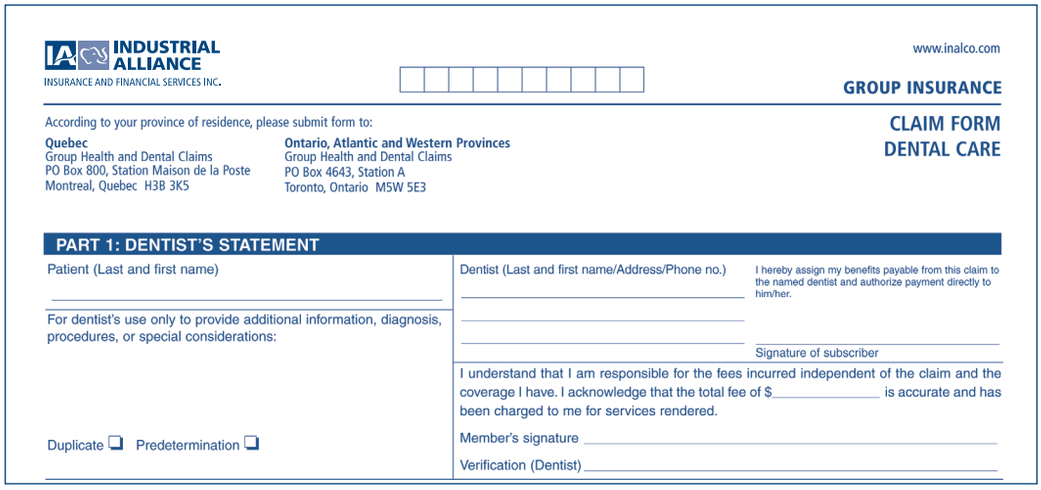
I hereby assign my benefits payable from this claim to the specified dentist and authorize payment directly to him/her.

F54-267A

2 - DENTAL CARE

2.1. Dental Care

If the dentist does not use electronic submission, the plan member must submit the *Dental Care* form (F54-288A) or the standard form available from the dentist, completed and signed in ink by the dentist and himself/herself.



INDUSTRIAL ALLIANCE
INSURANCE AND FINANCIAL SERVICES INC.

www.inalco.com

GROUP INSURANCE

CLAIM FORM
DENTAL CARE

According to your province of residence, please submit form to:

Quebec
Group Health and Dental Claims
PO Box 800, Station Maison de la Poste
Montreal, Quebec H3B 3K5

Ontario, Atlantic and Western Provinces
Group Health and Dental Claims
PO Box 4643, Station A
Toronto, Ontario M5W 5E3

PART 1: DENTIST'S STATEMENT

Patient (Last and first name)

For dentist's use only to provide additional information, diagnosis, procedures, or special considerations:

Duplicate ❑ Predetermination ❑

Dentist (Last and first name/Address/Phone no.)

I hereby assign my benefits payable from this claim to the named dentist and authorize payment directly to him/her.

Signature of subscriber

I understand that I am responsible for the fees incurred independent of the claim and the coverage I have. I acknowledge that the total fee of $_____ is accurate and has been charged to me for services rendered.

Member's signature

Verification (Dentist)

PART 2: MEMBER'S STATEMENT

Policy no. Policyholder's name

Member's last name First name

Certificate no. Date of birth Y M D Sex: ❑ M ❑ F Language: ❑ E ❑ F

COORDINATION OF BENEFITS

IMPORTANT NOTE:

- *If one of your dependents is covered under another plan for dental care expenses, the expenses incurred by this dependent must first be submitted to the other insurer. You may subsequently submit a claim for the balance, if applicable, under your plan.*
- *The expenses incurred by dependent children must be submitted to the plan of the parent whose birthday comes first during a calendar year.*

Are you or your dependents covered by another group plan? ❑ No ❑ Yes Specify:

Name of insurance company Policy no. Coverage: ❑ Individual ❑ Family

Name of spouse or child Date of birth Y M D

F54-288A

2.2. Treatment Program

For all requests regarding treatment for which the total cost exceeds $500, the plan member should submit a treatment program from the dentist before starting the treatment. To facilitate the evaluation of the reimbursable amount, also include the x-rays taken before the treatment. The x-rays will be returned to the dentist. Industrial Alliance will then specify the amount reimbursable under your group insurance policy.

3 - SHORT-TERM DISABILITY INCOME BENEFIT

3.1. Initial Request

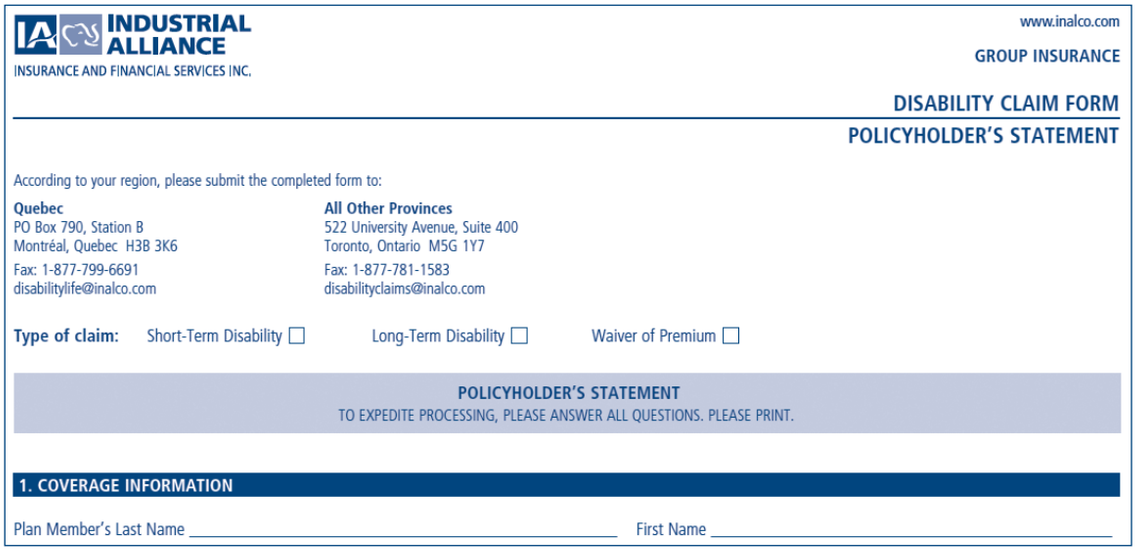
As plan administrator, you can initiate a new disability claim with Industrial Alliance in one of two ways:

- Simply call 1-877-422-6487; or
- Complete and submit the *Disability Claim Form – Policyholder's Statement* (F54-907A).

Industrial Alliance then conducts a detailed phone interview with the plan member to obtain the required personal and medical information.

The plan member will also be asked to complete and sign in ink the *Authorization for the Collection of Personal Information – Disability* form (F54-900A). Industrial Alliance will communicate directly with the attending physician(s).

In all cases, the decision is communicated to you and the plan member by phone and by letter.



INDUSTRIAL ALLIANCE
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www.inalco.com

GROUP INSURANCE

DISABILITY CLAIM FORM
POLICYHOLDER'S STATEMENT

According to your region, please submit the completed form to:

Quebec
PO Box 790, Station B
Montréal, Quebec H3B 3K6
Fax: 1-877-799-6691
disabilitylife@inalco.com

All Other Provinces
522 University Avenue, Suite 400
Toronto, Ontario M5G 1Y7
Fax: 1-877-781-1583
disabilityclaims@inalco.com

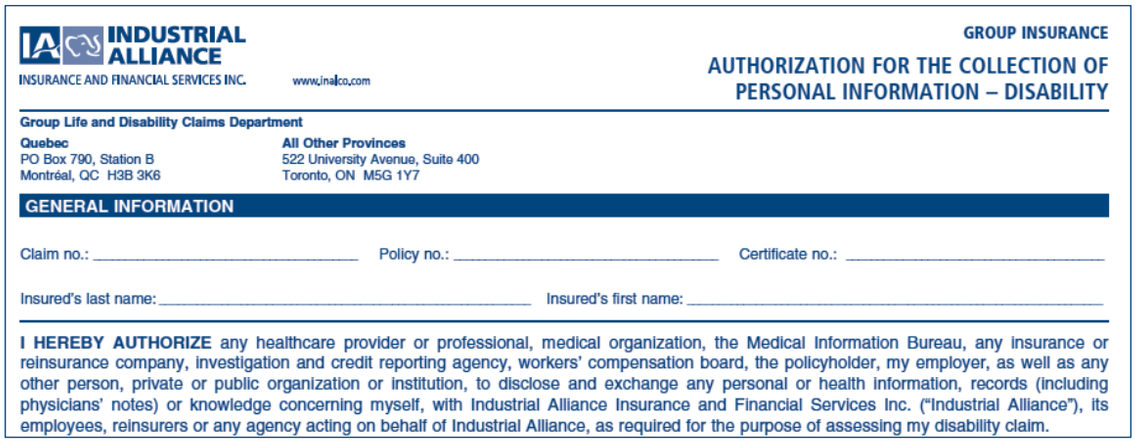
Type of claim: Short-Term Disability ☐ Long-Term Disability ☐ Waiver of Premium ☐

POLICYHOLDER'S STATEMENT
TO EXPEDITE PROCESSING, PLEASE ANSWER ALL QUESTIONS. PLEASE PRINT.

1. COVERAGE INFORMATION

Plan Member's Last Name _____ First Name _____

F54-907A



INDUSTRIAL ALLIANCE
INSURANCE AND FINANCIAL SERVICES INC. www.inalco.com

GROUP INSURANCE

AUTHORIZATION FOR THE COLLECTION OF PERSONAL INFORMATION – DISABILITY

Group Life and Disability Claims Department

Quebec
PO Box 790, Station B
Montréal, QC H3B 3K6

All Other Provinces
522 University Avenue, Suite 400
Toronto, ON M5G 1Y7

GENERAL INFORMATION

Claim no.: _____ Policy no.: _____ Certificate no.: _____

Insured's last name: _____ Insured's first name: _____

I HEREBY AUTHORIZE any healthcare provider or professional, medical organization, the Medical Information Bureau, any insurance or reinsurance company, investigation and credit reporting agency, workers' compensation board, the policyholder, my employer, as well as any other person, private or public organization or institution, to disclose and exchange any personal or health information, records (including physicians' notes) or knowledge concerning myself, with Industrial Alliance Insurance and Financial Services Inc. ("Industrial Alliance"), its employees, reinsurers or any agency acting on behalf of Industrial Alliance, as required for the purpose of assessing my disability claim.

F54-900A

3.2. Extension of Disability

If the disability continues beyond the date specified in the initial request, you must:

- Have the plan member and the attending physician complete the *Disability Claim Form – Extension of Disability* (F54-382A); or
- Provide the information requested by Industrial Alliance.

If you submit the *Disability Claim Form – Extension of Disability*, the plan member must sign in ink part 4, "Member Confirmation/Authorization" of the "Member's Statement", as well as the two parts preceding the "Attending Physician's Statement". The attending physician must complete the section corresponding to the patient's state of health (psychological or physical illness or both).

Do not detach the pages.

INDUSTRIAL ALLIANCE
INSURANCE AND FINANCIAL SERVICES INC.

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GROUP INSURANCE

DISABILITY CLAIM FORM
Extension of Disability

According to your region, please submit the completed form to:

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PO Box 790, Station B
Montréal, QC H3B 3K6

All Other Provinces
522 University Avenue, Suite 400
Toronto, Ontario M5G 1Y7

Type of claim: Short-Term Disability ☑ Long-Term Disability ❑ Waiver of Premium ❑

MEMBER'S STATEMENT
TO EXPEDITE PROCESSING, PLEASE ANSWER ALL QUESTIONS AND OBTAIN ALL REQUIRED SIGNATURES.

Please complete and return this form before Y M D

PART 4 – MEMBER CONFIRMATION/AUTHORIZATION

I CONFIRM that the statements provided in the Member's Statement and all statements provided in any personal or telephone interviews concerning this disability claim are true and complete to the best of my knowledge. I AGREE that all such statements form the basis for any benefits approved as a result of this claim.

I HEREBY AUTHORIZE:

(i) any healthcare provider or professional, medical organization, the Medical Information Bureau, insurance or reinsurance company, investigation and credit reporting agency, workers' compensation board, the policyholder, my employer, as well as any other person, private or public organization or institution to disclose and exchange any personal or health information, records (including physicians' notes) or knowledge concerning myself with Industrial Alliance Insurance and Financial Services Inc. (Industrial Alliance), its employees, reinsurers or agency acting on behalf of Industrial Alliance which is necessary for the purpose of assessing my disability claim;

(ii) Industrial Alliance to exchange any information with my employer/policyholder for the purpose of assessing my disability claim or discussing rehabilitation and return to work planning; and

(iii) Industrial Alliance and my employer/policyholder to use my SIN for identification purposes in the handling of my claim.

A photocopy of this Confirmation/Authorization shall be as valid as the original.

This Confirmation/Authorization is valid only for this disability claim.

Member's signature _____ Date Y M D

Address _____

Postal code Home tel. Work tel.

MEMBER AUTHORIZATION

I HEREBY AUTHORIZE any healthcare provider or professional, medical organization, the Medical Information Bureau, insurance or reinsurance company, investigation and credit reporting agency, workers' compensation board, the policyholder, my employer, as well as any other person, private or public organization or institution to disclose and exchange any personal or health information, records (including physicians' notes) or knowledge concerning myself with Industrial Alliance Insurance and Financial Services Inc. (Industrial Alliance), its employees, reinsurers or agency acting on behalf of Industrial Alliance which is necessary for the purpose of assessing my disability claim.

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Member's signature _____ Date Y M D

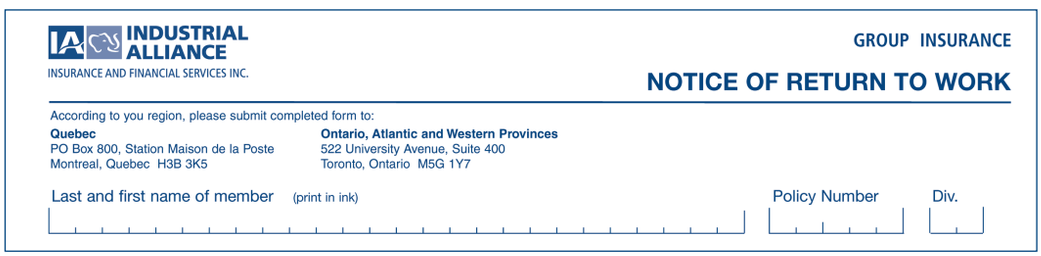
Address _____

Postal code Home tel. Work tel.

F54-382A

3.3. Return to Work

Complete the *Notice of Return to Work* form (F54-268A), specifying the type of return (gradual, part-time or full-time) and the number of hours worked per week.



INDUSTRIAL ALLIANCE
INSURANCE AND FINANCIAL SERVICES INC.

GROUP INSURANCE

NOTICE OF RETURN TO WORK

According to you region, please submit completed form to:

Quebec
PO Box 800, Station Maison de la Poste
Montreal, Quebec H3B 3K5

Ontario, Atlantic and Western Provinces
522 University Avenue, Suite 400
Toronto, Ontario M5G 1Y7

Last and first name of member (print in ink) Policy Number Div.

F54-268A

4 - LONG-TERM DISABILITY INCOME BENEFIT

4.1. Initial Request

Plans WITH the Short-Term Disability Income Benefit

Before the end of the Short-Term Disability benefit period, the plan member will be informed of the status of his/her Long-Term Disability claim and what further information, if any, is required.

Plans WITHOUT the Short-Term Disability Income Benefit

As plan administrator, you can initiate a new disability claim with Industrial Alliance in one of two ways:

- Simply call 1-877-422-6487; or
- Complete and submit the *Disability Claim Form – Policyholder's Statement* (F54-907A).

Industrial Alliance then conducts a detailed phone interview with the plan member to obtain the required personal and medical information.

The plan member will also be asked to complete and sign in ink the *Authorization for the Collection of Personal Information – Disability* form (F54-900A). Industrial Alliance will communicate directly with the attending physician(s).

In all cases, the decision is communicated to you and the plan member by phone and by letter.

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DISABILITY CLAIM FORM
POLICYHOLDER'S STATEMENT

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Type of claim: Short-Term Disability ☐ Long-Term Disability ☐ Waiver of Premium ☐

POLICYHOLDER'S STATEMENT
TO EXPEDITE PROCESSING, PLEASE ANSWER ALL QUESTIONS. PLEASE PRINT.

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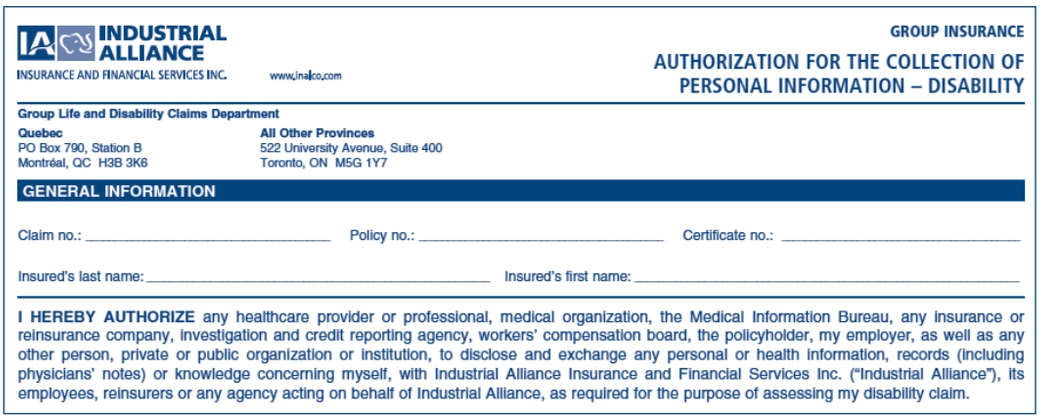
Plan Member's Last Name _____ First Name _____

F54-907A



INDUSTRIAL ALLIANCE
INSURANCE AND FINANCIAL SERVICES INC. www.inalco.com

GROUP INSURANCE

AUTHORIZATION FOR THE COLLECTION OF PERSONAL INFORMATION – DISABILITY

Group Life and Disability Claims Department

Quebec
PO Box 790, Station B
Montréal, QC H3B 3K6

All Other Provinces
522 University Avenue, Suite 400
Toronto, ON M5G 1Y7

GENERAL INFORMATION

Claim no.: _____ Policy no.: _____ Certificate no.: _____

Insured's last name: _____ Insured's first name: _____

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F54-900A

4.2. Extension of Disability

If the disability continues beyond the date specified in the initial request, you must:

› Have the plan member and the attending physician complete the *Disability Claim Form – Extension of Disability* (F54-382A); or

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If you submit the *Disability Claim Form – Extension of Disability*, the plan member must sign in ink part 4, "Member Confirmation/ Authorization" of the "Member's Statement", as well as the two parts preceding the "Attending Physician's Statement". The attending physician must complete the section corresponding to the patient's state of health (psychological or physical illness or both).

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INSURANCE AND FINANCIAL SERVICES INC.

inalco.com

GROUP INSURANCE

DISABILITY CLAIM FORM
Extension of Disability

According to your region, please submit the completed form to:

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PO Box 790, Station B
Montréal, QC H3B 3K6

All Other Provinces
522 University Avenue, Suite 400
Toronto, Ontario M5G 1Y7

Type of claim: Short-Term Disability ❑ Long-Term Disability ☑ Waiver of Premium ❑

MEMBER'S STATEMENT
TO EXPEDITE PROCESSING, PLEASE ANSWER ALL QUESTIONS AND OBTAIN ALL REQUIRED SIGNATURES.

Please complete and return this form before Y M D

PART 4 – MEMBER CONFIRMATION/AUTHORIZATION

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(ii) Industrial Alliance to exchange any information with my employer/policyholder for the purpose of assessing my disability claim or discussing rehabilitation and return to work planning; and

(iii) Industrial Alliance and my employer/policyholder to use my SIN for identification purposes in the handling of my claim.

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This Confirmation/Authorization is valid only for this disability claim.

Member's signature _____ Date Y M D

Address _____

Postal code | Home tel. | Work tel.

MEMBER AUTHORIZATION

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

This Authorization is valid only for this disability claim.

Member's signature _____ Date Y M D

Address _____

Postal code | Home tel. | Work tel.

F54-382A

4.3. Return to Work

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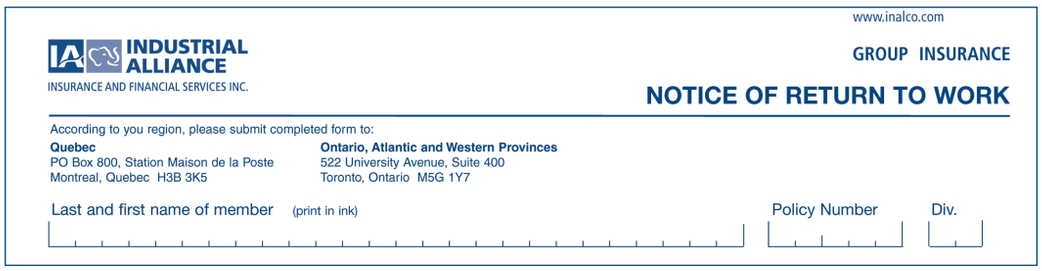


www.inalco.com

INDUSTRIAL ALLIANCE
INSURANCE AND FINANCIAL SERVICES INC.

GROUP INSURANCE

NOTICE OF RETURN TO WORK

According to you region, please submit completed form to:

Quebec
PO Box 800, Station Maison de la Poste
Montreal, Quebec H3B 3K5

Ontario, Atlantic and Western Provinces
522 University Avenue, Suite 400
Toronto, Ontario M5G 1Y7

Last and first name of member (print in ink) | Policy Number | Div.

F54-268A

5 - WAIVER OF PREMIUMS

Please contact Customer Service at 1-877-422-6487 to learn about the procedure to follow and the documents to submit, if any.

6 - LIFE INSURANCE

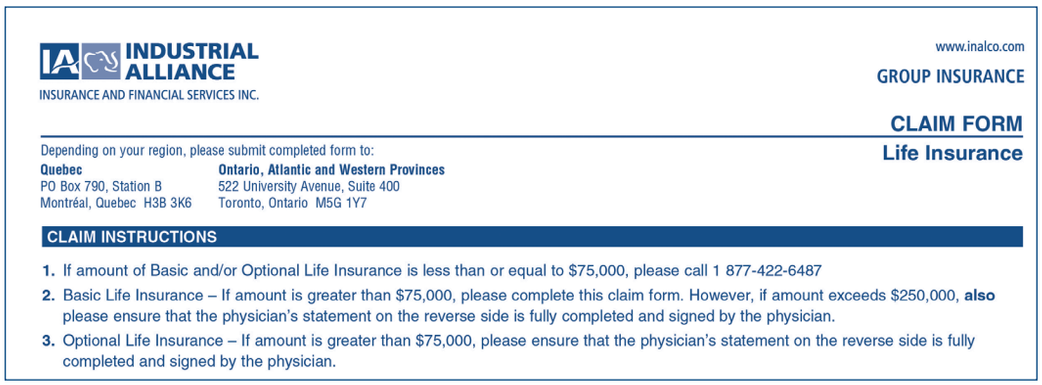
Upon the death of the plan member or one of his/her dependents, the life claim procedure depends on the insurance amount:

1. If the total amount of Basic and Optional Life and Accidental Death Insurance is less than or equal to $75,000, call 1-877-422-6487.
2. If the total amount of Basic and Optional Life and Accidental Death Insurance is greater than $75,000 and less than $250,000, submit the *Claim Form – Life Insurance* (F54-361A), duly completed and signed in ink, and one of the following:
   - The "Physician's Statement" section on the reverse side of the form, fully completed and signed by the physician; **or**
   - The official death certificate.
3. If the total amount of Basic and Optional Life and Accidental Death Insurance is equal to or greater than $250,000, submit the *Claim Form – Life Insurance* (F54-361A), duly completed, including the "Physician's Statement" section on the reverse side of the form, fully completed and signed by the physician, **and** the official death certificate.

When the *Claim Form – Life Insurance* (F54-361A) is required, it must be completed by each of the following:

- You, the plan administrator
- The plan member, if a dependent is deceased
- The beneficiary, if the plan member is deceased
- The physician, if applicable

Please note that dependents' coverage for some benefits may be temporarily extended after the death of the plan member without payment of premiums. Please refer to your group insurance policy for more details.



INDUSTRIAL ALLIANCE
INSURANCE AND FINANCIAL SERVICES INC.

www.inalco.com
GROUP INSURANCE

CLAIM FORM
Life Insurance

Depending on your region, please submit completed form to:

Quebec
PO Box 790, Station B
Montréal, Quebec H3B 3K6

Ontario, Atlantic and Western Provinces
522 University Avenue, Suite 400
Toronto, Ontario M5G 1Y7

CLAIM INSTRUCTIONS

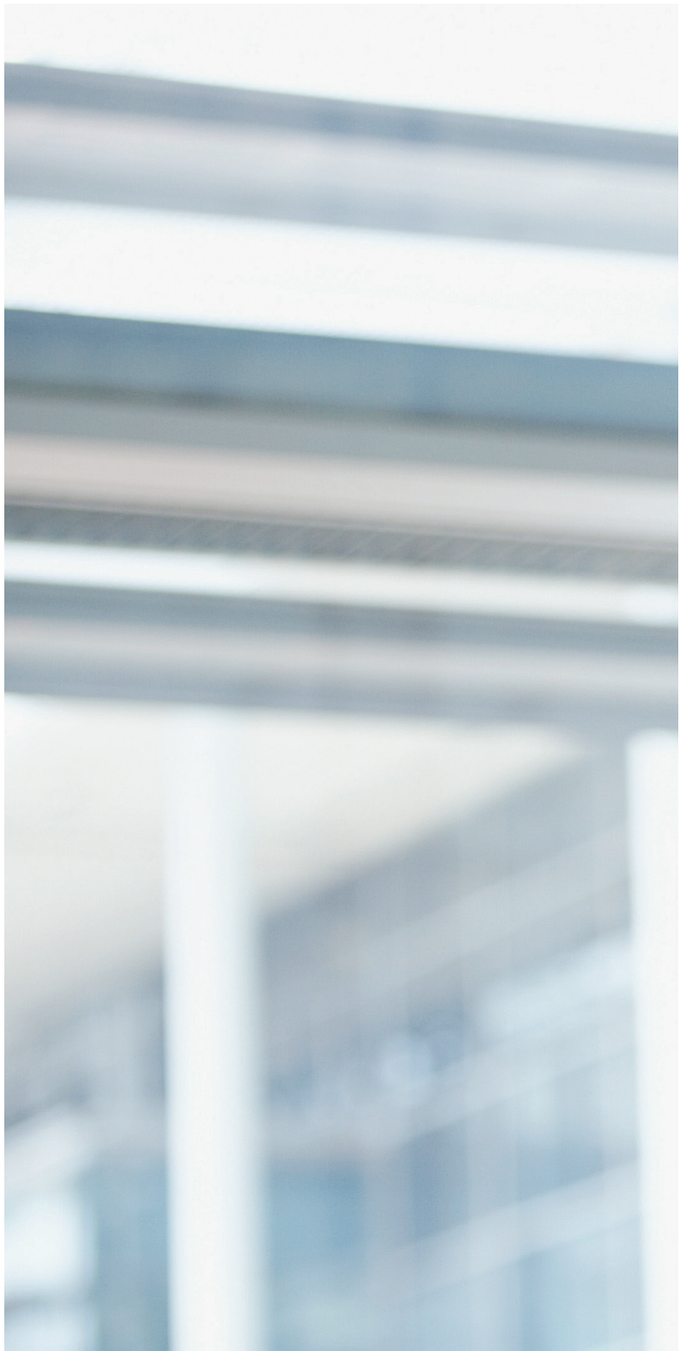
1. If amount of Basic and/or Optional Life Insurance is less than or equal to $75,000, please call 1 877-422-6487
2. Basic Life Insurance – If amount is greater than $75,000, please complete this claim form. However, if amount exceeds $250,000, **also** please ensure that the physician's statement on the reverse side is fully completed and signed by the physician.
3. Optional Life Insurance – If amount is greater than $75,000, please ensure that the physician's statement on the reverse side is fully completed and signed by the physician.

F54-361A

7 - ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

Please contact Customer Service at 1-877-422-6487 to learn about the procedure to follow and the documents to submit, if any.

NOTES



The elephant,
a symbol of our 120 years
of strength and solidity.

INDUSTRIAL ALLIANCE
INSURANCE AND FINANCIAL SERVICES

F54-703A(15-04)