Financial Group

INDIVIDUAL HEALTH INSURANCE APPLICATION TRANSIT

To convert group life insurance coverage, please complete the Request for conversion form (F54-030A).

Please print in ink and sign.

1. APPLICANT (PERSON TO BE INSURED)

Last name ______________________ First name ______________________

Address ______________________ Postal code
No. Street Apt. City Province

Date of birth Y M D Sex: ☐ Male ☐ Female Correspondence: ☐ English ☐ French

Personal phone no. Personal email Work email

2. REASON FOR APPLYING

☐ CONVERSION
of my group insurance coverage to individual health insurance (Complete section 3)

☐ CHANGE
to my individual insurance policy (Complete section 4)

3. CONVERSION

Group insurance policy no. __________ Certificate no. __________

Event leading to application for conversion: ______________________ Employment termination date Y M D

Coverage requested: Medical: ☐ INDIVIDUAL
☐ FAMILY (Complete section 5)

Module: ☐ BASIC OPTION
☐ ENHANCED OPTION

Dental (optional): ☐ INDIVIDUAL
☐ FAMILY (Complete section 5)
This option is only offered to participants who want to convert from a group insurance plan that includes dental coverage.

4. CHANGE

Contract no. 4 0 0 -

☐ I would like to add family coverage. (Complete section 5. If you want to add family coverage at a later date, doing so will depend on the provisions of your individual policy.)

☐ I would like to add one or more dependents. (Complete section 5.)

☐ I would like to terminate coverage for all my dependents as of Y M D .

☐ I would like to terminate coverage for ______________________ effective Y M D .
Name

☐ I would like to decrease medical coverage to module “Basic option” effective Y M D .

☐ I would like to increase medical coverage to module “Enhanced option” effective Y M D .

☐ I would like to terminate dental coverage effective Y M D .

5. DEPENDENTS

	Last name	First name	Sex	Date of birth	
Spouse			☐ M ☐ F	Y M D	☐ Married/Civil union ☐ Common-law: living together since Y M D
Child			☐ M ☐ F		If age 21 or over, specify: ☐ Full-time student ☐ Disabled
Child			☐ M ☐ F		If age 21 or over, specify: ☐ Full-time student ☐ Disabled

Please read and sign the second page of this form.

6. DIRECT DEPOSIT OF YOUR HEALTH AND/OR DENTAL CLAIM REIMBURSEMENTS AND NOTIFICATION

☐ Yes, I am subscribing to **direct deposit** to have my health and dental claim reimbursements automatically deposited in my bank account, and to be notified by email when claims have been processed.

Banking information: Include with this form a personal cheque marked VOID or a complete written confirmation from your financial institution.

Email for notification: ______________________________

☐ Personal ☐ Work

Note: You can view the status and details of your health and/or dental claims via My Client Space, our secure website, at any time.

APPLICANT CONFIRMATION/AUTHORIZATION

I HEREBY APPLY for the benefits which I am eligible for under the individual insurance plan of Industrial Alliance Insurance and Financial Services Inc. ("iA Financial Group"), subject to any refusal indicated and **CONFIRM** that the information contained in this form is true and complete to the best of my knowledge.

I CONFIRM that I am authorized to disclose information concerning my dependents and **I CONSENT**, on their behalf and on my own, to the release of the information provided to iA Financial Group, its employees, agents, reinsurers and service providers for the purpose of underwriting, administration, claims processing and the enrolment of myself and my dependents in an individual insurance plan by iA Financial Group.

If I enrol in direct deposit, **I AUTHORIZE** iA Financial Group to deposit in my bank account, using the banking information I have provided, any amounts payable in regards to a claim that I submit under my insurance policy. **I AGREE** that this authorization will apply until such time as I submit a written request to the contrary to iA Financial Group. **I UNDERSTAND** that iA Financial Group will have no further obligation with regard to the claims paid. **I ALSO UNDERSTAND** that iA Financial Group can, without prior notice, terminate the direct deposit of my claims payments. This authorization takes effect on the date indicated below and will be valid for all other active bank accounts at this or any other financial institution that I may name in the future.

Furthermore, if I enrol in direct deposit, **I UNDERSTAND** and **AGREE** that if I provide iA Financial Group with incorrect banking information or if I fail to notify iA Financial Group of any change in my banking information and, as a result of this error or omission, the amount of a paid claim is deposited into the wrong bank account, iA Financial Group cannot be held responsible or liable for this error or omission or be obligated to reimburse me if iA Financial Group is unable to recover the amount that was paid into the wrong account..

I AGREE that a photocopy of this Confirmation/Authorization shall be as valid as the original.

Applicant's signature ______________________________ Date Y M D

PRE-AUTHORIZED DEBIT (PAD) AGREEMENT – CATEGORY: PERSONAL

Banking information: Same as direct deposit. Otherwise, include with this form another personal cheque marked VOID or a complete written confirmation from your financial institution (indicate on it "PAD").

IMPORTANT: You must notify Industrial Alliance Insurance and Financial Services Inc. of any change in your banking information for PADs. Updating the banking information for your PADs does not update the banking information for your direct deposit, and vice versa. Therefore, each set of banking information must be updated separately.

In this PAD agreement, "I" refers to each bank account holder who, as it regards them, declares as follows:

Authorization

I authorize Industrial Alliance Insurance and Financial Services Inc. ("iA Financial Group") and the financial institution designated (or any other financial institution I may authorize at any time) to perform PADs from the bank account designated (or any other account I may designate at any time), for payment of premiums taxes, deposits, instalments and charges for the contract to which this agreement is attached. Regular periodic PADs will be processed on the 1st day of each month, whereas occasional one-time PADs can be processed on any other date.

If a PAD is refused for any reason (e.g., non-sufficient funds ["NSF"], stop payment, closed account, etc.), iA Financial Group is authorized to attempt the PAD again. Costs incurred by iA Financial Group resulting from the denied PAD will be added to the next PAD.

I agree that, for the purpose of this PAD agreement, all PADs from my account will be treated as personal.

I waive the right to receive an advance notice of an increase or decrease in the amount to be debited or a change in the date and/or frequency of these payments.

I agree that iA Financial Group is not required to provide me with written notice of a change in a PAD amount that is made as a result of my request.

I may cancel or modify this PAD agreement at any time, subject to providing iA Financial Group **thirty (30) days notice** in writing. To obtain a sample cancellation form or for more information on my right to cancel the PAD agreement, I may contact my financial institution or visit www.cdnpay.ca regarding Rule H1 – Pre-Authorized Debits (PADs).

Any cancellation of the PAD agreement will not affect my insurance contract(s) and/or contract(s) for financial services, so long as payment is provided by an alternate method.

iA Financial Group will not assign this PAD agreement without providing, any time prior to the next PAD, written notice to me of the assignment;

I have certain recourse rights if any PAD does not comply with this PAD agreement. For example, I have the right to receive reimbursement for any PAD that is not authorized or is not consistent with this PAD agreement. To obtain more information on my recourse rights, I may contact my financial institution or visit www.cdnpay.ca regarding Rule H1 – Pre-Authorized Debits (PADs).

Applicant's signature ______________________________ Date Y M D

DISCLOSURE

At Industrial Alliance Insurance and Financial Services Inc. (“iA Financial Group”), the personal information we collect concerning you and your dependents is kept strictly confidential and is only used for the purposes you have authorized.

Your personal file will be kept at iA Financial Group’s offices.

You have the right to request access to your personal information and, if necessary, correct any inaccurate information. In order to do so, send a written request to the following: Industrial Alliance Insurance and Financial Services Inc., Information Access Officer, 1080 Grande Allée West, PO Box 1907, Station Terminus, Quebec City, Quebec, G1K 7M3.

Access to your personal information will be limited to iA Financial Group’s employees, agents, reinsurers and service providers in the performance of their jobs, individuals to whom you have granted access, and persons authorized by law.

iiA Financial Group is a business name and trademark of
Industrial Alliance Insurance and Financial Services Inc.