**Underwritten by:**
Industrial Alliance Insurance & Financial Services Inc.
400–988 Broadway W PO Box 5900, Vancouver, BC V6B 5H6

FOR OFFICE USE ONLY

# REQUEST FOR NON-SMOKER RATES

Non-smoker rates apply to individuals who, at the time of application, have not used tobacco, nicotine, or cannabis mixed with tobacco in any form whatsoever within the last 12 months and who have provided satisfactory evidence of insurability.

**Please complete, print and sign.**

## POLICY INFORMATION

Name of Policyholder | Group Policy No. | Division No.

## MEMBER/EMPLOYEE INFORMATION THIS SECTION MUST ALWAYS BE COMPLETED

Last Name | Given Name | Initials | Member/Employee ID

Street Address | City | Prov. | Postal Code

Telephone (Home) | Telephone ( ◯ Work ◯ Cell ) | Email

## SPOUSE INFORMATION COMPLETE THIS SECTION WHEN SPOUSE IS APPLYING FOR NON-SMOKER RATES

Last Name | Given Name | Initials

## PERSONAL PHYSICIAN INFORMATION

**Member/Employee's Personal Physician Information**

Personal Physician's Name | Telephone

Street Address | City | Prov. | Postal Code

Date last consulted ANY Doctor (dd-mmm-yyyy) | Reason for consultation

Results (e.g. normal), diagnosis, treatment or medication prescribed

**Spouse's Personal Physician Information**

Personal Physician's Name | Telephone

Street Address | City | Prov. | Postal Code

Date last consulted ANY Doctor (dd-mmm-yyyy) | Reason for consultation

Results (e.g. normal), diagnosis, treatment or medication prescribed


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## HEALTH AND LIFESTYLE QUESTIONS

| | | Member/Employee Yes | Member/Employee No | Spouse Yes | Spouse No |
|---|---|---|---|---|---|
| 1) | **Member/Employee:** Height: ___ ◯ feet/inches ◯ cm Weight: ___ ◯ lbs ◯ kgs | | | | |
| 2) | **Spouse:** Height: ___ ◯ feet/inches ◯ cm Weight: ___ ◯ lbs ◯ kgs | | | | |
| 3) | In the last 12 months, have you used, in any form whatsoever, tobacco, nicotine or cannabis mixed with tobacco? If "Yes", indicate product used and provide details below. | ◯ | ◯ | ◯ | ◯ |
| 4) | Have you ever used any of the items listed in Question 3? If "Yes", please indicate which products were used and when usage stopped in the Additional Details section below. | ◯ | ◯ | ◯ | ◯ |
| 5) | Are you involved in the operation of an aircraft or involved in scuba diving, parachuting or any other hazardous sport? | ◯ | ◯ | ◯ | ◯ |
| 6) | Have you ever used marijuana, heroin, morphine, cocaine, LSD, barbiturates, amphetamines, or any other drug or narcotic, except as prescribed by your physician? | ◯ | ◯ | ◯ | ◯ |
| 7) | What is your present occupation? Give details of any proposed changes in the Additional Details section below: | | | | |
| 8) | Since your insurance coverage was issued : | | | | |
| | a) Have you ever had or ever been treated for cancer, tumour, cyst, polyp or other growth, moles, anemia, blood disorder or any form of malignant disease? Any immune system abnormality including AIDS (Acquired Immune Deficiency Syndrome), positive HIV test, enlargement of lymph glands, unusual skin lesions, or unexplained infections? | ◯ | ◯ | ◯ | ◯ |
| | b) Have you ever had or have you ever been treated for chest pain, angina, heart attack, high blood pressure, abnormal ECG, stroke, paralysis, transient ischemic attack (TIA), elevated cholesterol, or other disorders of the heart or aorta, blood vessels or circulatory system? Diabetes, pancreatitis, thyroid or other endocrine disorder? Lung or other respiratory disease or disorder? Any disorder of the eyes (excluding near or far sightedness), ears, vocal chords or larynx including loss of speech? | ◯ | ◯ | ◯ | ◯ |
| | c) Have you ever been treated for or diagnosed with kidney, bladder, prostate (including an elevated PSA test result) or breast disorder (including cysts, lumps, biopsy or abnormal mammogram or ultrasound) or other genitourinary disorder, hepatitis B or C (including carrier), cirrhosis or other liver disorder, ulcerative colitis, Crohn's disease or other disorder of the gastrointestinal tract? | ◯ | ◯ | ◯ | ◯ |
| | d) Have you ever had or have you ever been treated for dizziness, seizures, epilepsy, tremor, paresthesia, loss of balance, numbness, multiple sclerosis, Alzheimer's disease, Parkinson's disease, amyotrophic lateral sclerosis (ALS) or any other neurological disorder? Stress, anxiety, depression or any other psychiatric disorder? Disease or disorder of muscles, ligaments, tendons, bones or joints including but not limited to arthritis, lupus in any form, amputation or deformity? | ◯ | ◯ | ◯ | ◯ |
| | e) Have you any condition for which hospitalization, further testing, investigation or surgery has been advised, or which have not yet been done? | ◯ | ◯ | ◯ | ◯ |
| | f) Do you have any reason to believe you are suffering from any disorder, or are you taking any prescribed medication? | ◯ | ◯ | ◯ | ◯ |
| | g) Have you consulted a physician or received treatment for any disease, disorder, ailment or injury not already mentioned? | ◯ | ◯ | ◯ | ◯ |
| | h) Have you ever had a request for life, critical illness or health insurance declined, postponed, rated, or restricted in any way? If "Yes" please provide reason. | ◯ | ◯ | ◯ | ◯ |

## ADDITIONAL DETAILS IF ANY OF QUESTIONS ARE ANSWERED "YES", PROVIDE DETAILS BELOW

| **Question Number** | **Name of person to be insured** | **Details (include dates and durations, etc.)**<br>**If you require more space, please attach a separate sheet of paper, signed and dated.** |
|---|---|---|
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## AUTHORIZATION FORM MUST BE SIGNED IN INK

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

1) any health care professional as well as any other public or private health or social service establishment, any insurance company, the Medical Information Bureau, any insurance plan sponsor, any agent, broker or market intermediary, any third party administrator, any personal information agents or professional investigation agencies and any government agency, or other organization, institution or person that has any records or knowledge of me or my health, to give to Industrial Alliance Insurance and Financial Services Inc. (the "Company") or its reinsurers any such information for the purpose of the risk assessment, administration or investigation of a subsequent claim.
2) the Company or its reinsurers to release and exchange any personal information obtained to the above persons and organizations for the purposes of assessment of this application, the administration of any certificate issued and the investigation of any claim.
3) the Company 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.
4) the Company to release any abnormal test results to my personal physician.

I acknowledge that all correspondence relating to this application, including the requirement for additional medical information and the communication of any underwriting decision, will be directed to the applicant.

I confirm that the foregoing answers, forming part of an application for group insurance to the Company are true, full, complete and correctly recorded, and together with any other forms signed by me in connection with this application form the basis for any certificate issued hereunder. I understand that any group insurance arising from this application may not be valid if there is any incorrect answer or misrepresentation in this application or if there is any change in my insurability between the date of this application and the effective date of coverage. I acknowledge that it is my responsibility to notify the Company of any change in my health or insurability. I agree that my insurance will not take effect until my properly completed application has been approved by the Company and the first month's premium has been paid.

A copy of this signed authorization shall be as valid as the original.

| X | | X | |
|---|---|---|---|
| **Member/Employee Signature** (must always sign) | Date (dd-mmm-yyyy) | **Spouse Signature** (if applying) | Date (dd-mmm-yyyy) |

## YOUR PERSONAL INFORMATION

The personal information that we, iA Financial Group and its affiliates, collect in the course of your application will only be used and disclosed for the purposes for which you have already consented.

To review your consent preferences or to learn more, please visit ia.ca/protection-personal-information.



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## DISCLOSURE NOTICE - MEDICAL INFORMATION BUREAU PLEASE READ CAREFULLY AND RETAIN FOR YOUR RECORDS

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

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

The Company may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

## SEND YOUR COMPLETED FORM TO

**iA Special Markets**
Industrial Alliance Insurance and Financial Services Inc.
400 – 988 Broadway W, PO Box 5900, Vancouver, BC V6B 5H6

## QUESTIONS?

Contact a Client Service Specialist at:
**1.800.266.5667** (toll-free)
**604.737.3802** (Vancouver)
**specialmarkets@ia.ca**
Monday to Friday 6:30 a.m. - 4:30 p.m. Pacific Time


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