

SUPPLEMENTAL QUESTIONNAIRE FOR DEPENDENT CHILD INSURANCE

Complete one questionnaire for each eligible dependent child you are applying for.

POLICY INFORMATION

Name of Policyholder	Group Policy Number	Division Number	Member/Employee ID
<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>

MEMBER/EMPLOYEE INFORMATION MUST ALWAYS BE COMPLETED

Last Name	Given Name	Initials	Gender	Date of Birth (dd-mmm-yyyy)
<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input type="radio"/> Male <input type="radio"/> Female	<input style="width: 95%;" type="text"/>
Street Address	City	Prov.	Postal Code	
<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	
Telephone (Home)	Telephone (<input type="radio"/> Work <input type="radio"/> Cell)	Email		
<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>		

COVERAGE SELECTION

Type of insurance requested	Total amount of insurance requested (include any existing amounts)
<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>
Type of insurance requested	Total amount of insurance requested (include any existing amounts)
<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>

DEPENDENT CHILD INFORMATION

Last Name	Given Name	Initials	Gender	Date of Birth (dd-mmm-yyyy)
<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input type="radio"/> Male <input type="radio"/> Female	<input style="width: 95%;" type="text"/>
Place of Birth				
<input style="width: 95%;" type="text"/>				

Please select one which best represents your Dependent Child:

- Child**
 Dependent who is over 14 days of age and under 21 years of age, unmarried and receives full parental support and maintenance.
- Full-Time Post Secondary Student**
 Dependent who is 21 years of age or over but under 25 years of age, unmarried and receives full parental support and maintenance for reason of full-time attendance at a recognized school, college or university.

Height	Weight
<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>
<input type="radio"/> ft/in <input type="radio"/> cm	<input type="radio"/> lbs <input type="radio"/> kgs
Name of Education Institution	
<input style="width: 95%;" type="text"/>	

1. **Has there been a weight loss or gain of more than 10 lbs during the last 12 months?** Yes No
 If "Yes", please answer the following:

What was the amount of the weight change?	Was this a gain or a loss?	Reason
<input style="width: 95%;" type="text"/>	<input type="radio"/> Gain <input type="radio"/> Loss	<input style="width: 95%;" type="text"/>
2. **Has the proposed Dependent Child ever applied for any insurance that was declined, modified or rated?** Yes No
 If "Yes", provide details including date, name of company and reason for the decline, modification or rating.
3. **Does your Dependent Child intend to travel or reside outside Canada or the United States for more than one month?** Yes No
 If "Yes", provide dates of travel, cities and countries and reason for travel.
4. **Is your Dependent Child in good health and free from any symptoms and/or diagnosis or any illness, disease, disorder, or any physical or mental abnormalities?** Yes No
 If "No", provide details.

FAMILY HISTORY QUESTION MUST ALWAYS BE COMPLETED WHEN APPLYING

Have any of the dependent child's biological parents, grandparents, brothers or sisters ever undergone bypass surgery or suffered from any of the following conditions: Heart attack, angina, or any other heart condition, stroke, polycystic kidney disease, diabetes, cancer (if "Yes" specify type), Alzheimer's disease, Parkinson's disease, multiple sclerosis, amyotrophic lateral sclerosis (ALS), Huntington's disease, alcoholism, nervous or mental disorder, or any other hereditary disease?

Yes No

If "Yes"; please complete the following table. If you require more space, please attach a separate sheet of paper, signed and dated.

	Present Age (If Living)	Condition	Age at Onset/ Diagnosis	Age at Death (if applicable)
Father				
Mother				
Brothers				
Sisters				
Maternal Grandparents				
Paternal Grandparents				

PERSONAL PHYSICIAN INFORMATION

Dependent Child'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 _____

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:

- 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 my dependent child's 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.
- 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.
- the Company to test and evaluate a specimen of my dependent child's blood, urine or saliva for the purpose of assessing my dependent child as an insurance risk. This analysis includes testing for HIV infection.
- the Company to release any abnormal test results to my dependent child's personal physician.

I confirm that I am authorized to disclose information concerning my dependent child for the purpose of determining their eligibility for coverage.

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 member/employee.

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 dependent child's 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 dependent child's 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.

(For Quebec residents) I confirm that all the applicants under age 65 are covered under a private drug plan as required by the Quebec Act respecting prescription drug insurance. I understand that coverage may be void if this declaration is false.

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.

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

X _____
Member/Employee Signature (must always sign) _____
 Date (dd-mmm-yyyy) _____

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