

APPLICATION FOR GROUP INSURANCE SPOUSE/PLAN MEMBER

Please complete, print and sign.

For spouse/plan member who do not have a valid Cat.1 or Class 1 medical certificate.

POLICY INFORMATION

Name of Policyholder Professional Pilot Insurance Plan	Group Policy Number 100007521
---	----------------------------------

MEMBER INFORMATION MUST ALWAYS BE COMPLETED

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

SPOUSE INFORMATION COMPLETE THIS SECTION WHEN APPLYING FOR SPOUSAL COVERAGE

Are you also a member of PPIP? Yes No If "Yes", please complete a separate application.

What is your spousal status? Married Civil Union Common-Law, please provide date of cohabitation (dd-mmm-yyyy) _____

Last Name	Given Name	Initials	Gender <input type="radio"/> Male <input type="radio"/> Female	Date of Birth (dd-mmm-yyyy)
Place of Birth	Occupation			

INSURANCE INFORMATION SELECT INSURANCE APPLYING FOR

Member Term Life Insurance
 (Units of \$50,000 to \$500,000 max.)

Total amount of insurance requested (include any existing amounts)

+

Dependent Term Life Insurance
 Compulsory for Plan Members with dependents. \$1.90 per month covers all eligible dependents. Dependent family members are each covered for a life benefit of \$5,000.

I would like to opt-out of Dependent Term Life Insurance as I do not have a spouse and/or and dependent children

Accidental Death, Disease & Dismemberment Insurance Coverage equals amount of Member Term Life Insurance

Spouse Term Life Insurance
 (Units of \$50,000 to \$500,000 max.)

Total amount of insurance requested (include any existing amounts)

HEALTH AND LIFESTYLE QUESTIONS MUST ALWAYS BE COMPLETED WHEN APPLYING
If you answer "Yes" to any question below (or "No" to question 8), please complete the Additional Details section below.

1) Member:	Height: <input type="text"/> <input type="radio"/> ft/in <input type="radio"/> cm	Weight: <input type="text"/> <input type="radio"/> lbs <input type="radio"/> kgs				
2) Spouse:	Height: <input type="text"/> <input type="radio"/> ft/in <input type="radio"/> cm	Weight: <input type="text"/> <input type="radio"/> lbs <input type="radio"/> kgs				
			Member	Spouse		
			Yes No	Yes No		
3)	In the last 12 months, have you used, in any form whatsoever, tobacco, nicotine or cannabis mixed with tobacco?		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4)	Have you flown as a pilot, student or crew member in the last two years or do you have any intention to do so?		N/A		<input type="radio"/>	<input type="radio"/>
5)	Have you engaged in or do you intend to participate in scuba diving, parachuting or other hazardous sport or activity?		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6)	Do you intend to travel or reside outside Canada or the United States for more than a month?		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7)	Have you had a request for life, disability or critical illness insurance declined, postponed, rated or modified in any way?		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8)	Are you now actively engaged in your occupation on a full-time basis? If "No," please provide details including reason why you are not working on a full-time basis.		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9)	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?		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10)	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?		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11)	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?		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12)	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?		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
13)	Have you ever used marijuana, heroin, morphine, cocaine, LSD, barbiturates, amphetamines, or any other drug or narcotic, except as prescribed by your physician?		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
14)	a) Do you presently drink more than 12 alcoholic beverages per week? If "Yes," state number, kind and frequency consumed.		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	b) Have you ever changed your pattern of drinking (increased or decreased), received advice or treatment for, or attended any rehabilitation program for alcohol or drug use?		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
15)	Have you any condition for which hospitalization, further testing, investigation or surgery has been advised, or which have not yet been done, or for which you are still awaiting results?		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
16)	Are you taking any prescribed medication? If "Yes," state name of medication and reason for use.		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
17)	Are you aware of any symptoms or complaints regarding your health for which you have not yet consulted a physician or received treatment?		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
18)	Have you been absent from work for more than seven consecutive days within the past year due to sickness or injury?		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
19)	Has there been a variation in your weight in the past year? If "Yes," please provide details including reason and number of pounds/kilograms gained or lost.		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
20)	Are you currently pregnant? If "Yes," please provide your estimated due date and advise of any complications with current or past pregnancies.		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
21)	During the past 10 years, have you consulted a physician, received treatment or been hospitalized, had surgery or any test (other than routine checkup or minor injury) for any disease, disorder or ailment not already mentioned?		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
22)	Have you ever received or claimed benefits or a pension for sickness, injury or impairment?		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
23)	Do you have any pending criminal offences, criminal convictions, had your driver's license suspended, or within the past 3 years been convicted of more than 3 traffic violations?		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
24)	Have any immediate relatives had tuberculosis, diabetes, epilepsy, cancer, high blood pressure, heart or kidney disease, alcoholism, nervous or mental disorder, or any hereditary disease before age 65? If yes, who and what illness?		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

ADDITIONAL DETAILS IF YOU ANSWER "YES" TO ANY QUESTION OR "NO" TO QUESTION 8, PROVIDE DETAILS BELOW

Question Number	Name of person to be insured	Details (include dates, duration and names and addresses of all doctors, hospitals, etc.). If you require more space, please attach a separate sheet of paper, signed and dated.

PERSONAL PHYSICIAN INFORMATION

Member's Personal Physician Information

Personal Physician's Name		Telephone	
Street Address		City	Prov. Postal Code
Date last consulted <u>ANY</u> 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 <u>ANY</u> Doctor (dd-mmm-yyyy)	Reason for consultation		
Results (e.g. normal), diagnosis, treatment or medication prescribed			

BENEFICIARY DESIGNATION MUST BE COMPLETED WHEN APPLYING FOR TERM LIFE AND/OR ACCIDENTAL DEATH, DISEASE & DISMEMBERMENT

The beneficiary designation stated on this application will supersede all prior dated revocable designations. Unless specific instructions to the contrary have been received by Industrial Alliance Insurance and Financial Services Inc., this designation will apply in the event of the member's death to benefits payable under the member's Voluntary Term Life and Accidental Death, Disease and Dismemberment Insurance in force under this group policy. You may change your beneficiary at any time without the beneficiary's consent, unless you specifically designate your beneficiary as irrevocable.

Beneficiary Last Name	Beneficiary Given Name	Relationship to Member	% Payable to Each

For any beneficiary under 18 you must also name a trustee (not applicable in the province of Quebec)

Name of Trustee

Unless otherwise stated in writing, the member is the beneficiary for any spouse and/or Dependent Term Life benefits.

NOTE FOR QUEBEC RESIDENTS

If you have named your spouse (excluding common-law spouse) as your beneficiary, this designation will automatically be irrevocable. This means that you will not be able to change your coverage without their consent.

If you do not wish your spouse's designation to be irrevocable, please check here → **Revocable**

PAYMENT INFORMATION PLEASE CHOOSE YOUR PAYMENT OPTION BELOW

- Monthly Pre-Authorized Debit (PAD)**
I have completed the attached Pre-Authorized Debit (PAD) Agreement form authorizing Industrial Alliance Insurance and Financial Services Inc. (the "Company") to withdraw the required premium (plus applicable taxes) from my account.
- Cheque**
I have attached a cheque for the first month's premium payable to "iA Financial Group". I understand the balance of the premium (plus applicable taxes) will be billed once my coverage is approved.
- For existing clients only**
Use my current payment method.
- Bill me**
Send me a Premium Statement once my coverage has been approved. I understand coverage will not take effect until my first month's premium has been received.

DECLARATION AND 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:

- a) 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.
- b) 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.
- c) 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.
- d) 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.

(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.

CLIENT CONSENT**YOUR PERSONAL INFORMATION IS IMPORTANT.**

For **you**, because it involves your privacy. For **us**, iA Financial Group and its affiliates, because it allows us to better serve you day by day.

Protecting your personal information is important to us.

By doing business with us, you agree to the collection, use and disclosure of personal information necessary to:

- **Know who you are.**
Identify you and keep your contact information up to date.
- **Build a relationship with you.**
Advise you according to your needs, analyze your requests and identify the products and services that are right for you.
- **Maintain our relationship with you.**
Administer your products and services and process your requests, complaints and claims.
- **Comply with the laws and manage risk.**
For instance, with regard to cybersecurity or the fight against financial crime.

We want to inform you.

Under certain conditions, we may disclose your personal information to our representatives, agents, and partners, or any other third party, **if and only if** this disclosure:

- is necessary to serve you, or
- is made in respect of the choices you have made, or
- is in accordance with the law.

We are committed to sharing only necessary information.

To learn more, please visit ia.ca/protection-personal-information.

As the Member, YOU CONFIRM that you are authorized to disclose information concerning your dependents and YOU CONSENT, on their behalf, to the collection, use and disclosure to your Policyholder, our agents, reinsurers and service providers, of the information you have provided and that is necessary to benefit from your Policyholder's group insurance plan.

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

X

Member Signature
(must always sign)

Date (dd-mmm-yyyy)

X

Spouse Signature
(if applying)

Date (dd-mmm-yyyy)

PRE-AUTHORIZED DEBIT (PAD) AGREEMENT

Please complete, print and sign.

MEMBER INFORMATION

Last Name	Given Name	Initials
<input type="text"/>	<input type="text"/>	<input type="text"/>

CHEQUE/ACCOUNT DETAILS FOR MONTHLY PRE-AUTHORIZED DEBITS

PLEASE ATTACH A PERSONALIZED 'VOID' CHEQUE OR COMPLETE THE INFORMATION BELOW.
IF YOU DON'T HAVE A CHEQUE, YOU CAN REQUEST A DIRECT DEPOSIT FORM FROM YOUR FINANCIAL INSTITUTION.

Name(s) of Account Holder(s) as shown on Financial Institution records			
<input type="text"/>			
Street Address of Account Holder(s)	City	Prov.	Postal Code
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Name of Financial Institution			
<input type="text"/>			
Street Address of Branch	City	Prov.	Postal Code
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

PAD CATEGORY IF THIS IS NOT FILLED IN, THE PAD WILL BE TREATED AS PERSONAL

Personal Expense Business Expense

Withdrawal Arrangement

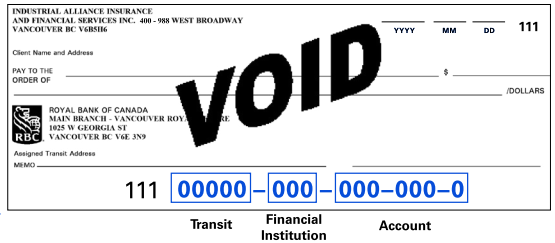
Fixed Variable

Transit Number (See sample →)

Financial Institution Number (See sample →)

Account Number (See sample →)

Sample →



Recourse

You have certain recourse rights if any debit does not comply with this agreement. For example, you have the right to receive reimbursement for any debit that is not authorized or is not consistent with this PAD Agreement. To obtain more information on your recourse rights, contact your financial institution or visit www.payments.ca.

AUTHORIZATION FORM MUST BE SIGNED IN INK

I/we, as the Account Holder(s), authorize Industrial Alliance Insurance and Financial Services Inc. (the "Company") and the financial institution named above or as indicated on the attached 'VOID' cheque, to withdraw variable monthly payments from my/our account, at the branch indicated, for the purpose of collecting premiums and any applicable sales tax for insurance under this policy.

The PAD amount will be debited from the account indicated above on the 1st day of each month or the next business day. I/we agree to notify the Company in writing, if there is any change to the banking information set out above.

I/we waive the right to receive pre-notification of the amount to be debited each month and the date of such debit. However, the Company will provide written notice of the amount of the first PAD at least three (3) calendar days before the first PAD is debited.

I/we may cancel this PAD Agreement at any time, subject to providing notice to the Company at the address provided below. This notification must be received at least ten (10) business days before the next debit is scheduled. I/we may obtain a sample cancellation form, or more information on my/our right to cancel a PAD Agreement at my/our financial institution or by visiting www.payments.ca.

I/we understand that cancellation of this PAD Agreement will not have any effect on the insurance provided under this policy, provided that payment is received when due and is made in accordance with the terms of this policy.

This PAD Agreement only applies to the method of payment. I/we understand that completing this PAD Agreement does not mean that the application for insurance coverage has been approved.

X

Member Signature
(must always sign)

Date (dd-mmm-yyyy)

X

Signature of all other Account Holder(s)
(if a required signatory to this account)

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