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

FOR OFFICE USE ONLY

APPLICATION FOR MEMBER GROUP INSURANCE

Please complete, print and sign.

For Members with a valid Cat.1 or Class 1 medical certificate

INSTRUCTIONS

- Plan Members enrolling in Voluntary Life Insurance, complete this form.
- For new or increased coverage, attach a photocopy of your valid and current Cat. 1 or Class 1 medical certificate.
- If you do not have a valid Cat.1 or Class 1 medical certificate, please complete the Form 6337: Application for Group Insurance Spouse/Plan Member.
- To apply for Spousal Voluntary Life Insurance, please complete Form 6337: Application for Group Insurance Spouse/Plan Member

POLICY INFORMATION

Name of Policyholder	Group Policy Number
Canadian Federal Pilots Association	100012181

MEMBER INFORMATION MUST ALWAYS BE COMPLETED

Last Name

Given Name

Initials

Gender
◯ Male
◯ Female

Date of Birth (dd-mmm-yyyy)

Preferred Given Name

Street Address

City

Prov.

Postal Code

Telephone (Home)

Telephone (◯ Work ◯ Cell)

Email

INSURANCE INFORMATION

FOR NEW OR INCREASED COVERAGE, ATTACH A PHOTOCOPY OF YOUR VALID AND CURRENT CAT. 1 OR CLASS 1 MEDICAL CERTIFICATE

◯ **Member Term Life Insurance**
(Units of $50,000 to $500,000 max.)
+
Dependent Term Life Insurance
Compulsory for Plan Members with dependents. $2.30 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*

Total amount of insurance requested (include any existing amounts)

◯ **Accidental Death, Disease & Dismemberment Insurance**

Coverage equals amount of Member Term Life Insurance

MEMBER HEALTH AND LIFESTYLE QUESTIONS MUST ALWAYS BE COMPLETED WHEN APPLYING

		Yes	No
1)	In the last 12 months, have you used, in any form whatsoever, tobacco, nicotine or cannabis mixed with tobacco? If yes, indicate which product is used, how long you have been using it and your daily usage:	◯	◯
2)	Are you now to the best of your knowledge and belief, in good health and free from all symptoms of illness and disease and are you free from any condition that could possibly prevent you from passing your Transport Canada medical?	◯	◯
3)	Are you a resident of Canada?	◯	◯

iA Financial Group

BENEFICIARY DESIGNATION

MUST BE COMPLETED WHEN APPLYING FOR VOLUNTARY GROUP LIFE AND/OR ACCIDENTAL DEATH, DISEASE & DISMEMBERMENT INSURANCE

Percentage allocation will be deemed equal unless indicated otherwise. Percentages must total 100%.

If you do not name a beneficiary, your "estate" will automatically be assigned as your beneficiary.

Primary Beneficiary Last Name	Beneficiary Given Name	Relationship to Member	% Payable to Each
Primary Beneficiary Last Name	Beneficiary Given Name	Relationship to Member	% Payable to Each
Contingent 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 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 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 further acknowledge receipt of the Notice on Privacy and Confidentiality (attached) summarizing certain privacy practices regarding collection, use and disclosure of my personal information.

I agree to the use of my personal information for the purposes outlined in this application. I understand that my consent to the use of any information to offer me products and services is optional and that if I wish to discontinue such use I may call or write to the Company at the telephone number or address shown on this application.

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.

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

X

Member Signature
(must always sign)

Date (dd-mmm-yyyy)

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iA Financial Group

PRE-AUTHORIZED DEBIT (PAD) AGREEMENT

Please complete, print and sign.

MEMBER INFORMATION

Last Name	Given Name	Initials

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

Street Address of Account Holder(s)	City	Prov.	Postal Code

Name of Financial Institution

Street Address of Branch	City	Prov.	Postal Code

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

◯ **Personal Expense** ◯ **Business Expense**

Withdrawal Arrangement

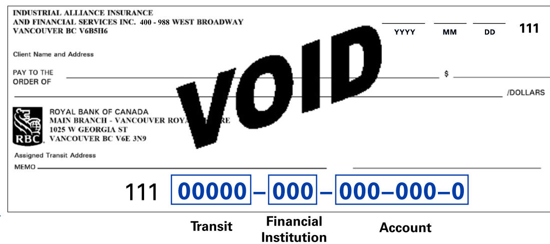
◯ Fixed ◯ Variable

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		X	
Member Signature (must always sign)	Date (dd-mmm-yyyy)	**Signature of all other Account Holder(s)** (if a required signatory to this account)	Date (dd-mmm-yyyy)

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NOTICE ON PRIVACY & CONFIDENTIALITY PLEASE READ CAREFULLY AND RETAIN FOR YOUR RECORDS

The specific and detailed information requested pursuant to this application from you and which may be subsequently requested by us, from time to time, is required to process your application, and process any claim for benefits made by you. To protect the confidentiality of such personal information, access to your information is restricted to any person you authorize or as authorized by law as well as those Industrial Alliance Insurance and Financial Services Inc. (the "Company") employees, its reinsurers, third party administrators, agents or brokers of the Company, plan sponsors and any agents or brokers of such sponsors or other market intermediaries for the purposes of (a) sponsoring a plan for you, (b) marketing and administration of Company products or services, (c) assessment of risk (underwriting) and (d) investigation of claims (where applicable). **Your file will be kept in our offices.**

You are entitled to review your personal information contained in our files, subject to certain limited exceptions established by law, and if necessary, to have it rectified by sending a written request to us at: 400–988 West Broadway. P.O. Box 5900, Vancouver, BC V6B 5H6, Attention: Director, iA Special Markets. Corrections will be noted in the file. If a requested correction is in dispute, we nonetheless note your requested correction in the file. Further information on our privacy practices can be found online at ia.ca or alternatively, contact us at 1.800.266.5667 and request that a copy be faxed or mailed to you.

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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