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

FOR OFFICE USE ONLY

SIMPLIFIED APPLICATION FOR VOLUNTARY GROUP INSURANCE

Please complete, print and sign.

POLICY INFORMATION

Name of Policyholder: BPA Financial Group

Group Policy Number: 100013202

MEMBER INFORMATION MUST ALWAYS BE COMPLETED

Last Name | Given Name | Initials | Gender (◯ Male ◯ Female) | Date of Birth (dd-mmm-yyyy)

Street Address | City | Prov. -- | Postal Code

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

SPOUSE INFORMATION COMPLETE THIS SECTION WHEN APPLYING FOR SPOUSAL COVERAGE

Are you also a member of the Policyholder? ◯ 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 (◯ Male ◯ Female) | Date of Birth (dd-mmm-yyyy)

INSURANCE INFORMATION SELECT INSURANCE APPLYING FOR

◯ **Member Term Life Insurance**
(Units of $10,000 to $100,000 max.)
Total amount of insurance requested (include any existing amounts)

◯ **Member Critical Illness Insurance**
(Units of $10,000 to $50,000 max.)
Total amount of insurance requested (include any existing amounts)

◯ **Spouse Term Life Insurance**
(Units of $10,000 to $100,000 max.)
Total amount of insurance requested (include any existing amounts)

◯ **Spouse Critical Illness Insurance**
(Units of $10,000 to $50,000 max.)
Total amount of insurance requested (include any existing amounts)

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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.

		Member		Spouse	
		Yes	No	Yes	No
Member: Height: ◯ ft/in ◯ cm Weight: ◯ lbs ◯ kgs					
Spouse: Height: ◯ ft/in ◯ cm Weight: ◯ lbs ◯ kgs					
1)	In the last 12 months, have you used, in any form whatsoever, tobacco, nicotine or cannabis mixed with tobacco?	◯	◯	◯	◯
2)	Have you ever been diagnosed with, received treatment in any form for, or had any indication of: Cancer, Tumour, Hepatitis B or C, Diabetes, HIV or AIDS, Liver or Kidney disease, Heart Disease, Diabetes, Stroke, Transient Ischemic Attack (TIA or mini-stroke), Disorder of the blood, Paralysis, Multiple Sclerosis, Parkinson Disease, Alzheimer's Disease, Huntington Disease, Amyotrophic Lateral Sclerosis (ALS), Total Loss of Speech, Vision, or Deafness, or other neurological disease?	◯	◯	◯	◯
3)	For drug or alcohol use, has a medical professional ever recommended you to reduce consumption, undergo treatment, or receive counselling?	◯	◯	◯	◯
4)	Are you currently: • receiving disability benefits, • unable to independently perform daily living activities (bathing, dressing, feeding, toileting), • confined to a hospital or health institution, • been recommended to undergo testing, investigations, or a specialist consult that is yet to be completed (including awaiting any test results)	◯	◯	◯	◯

BENEFICIARY DESIGNATION MUST BE COMPLETED WHEN APPLYING FOR TERM LIFE

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 Term Life 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
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 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**

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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 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.

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

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

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PRE-AUTHORIZED DEBIT (PAD) AGREEMENT

Please complete, print and sign.

POLICY INFORMATION

Name of Policyholder: BPA Financial Group

Group Policy Number: 100013202

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**

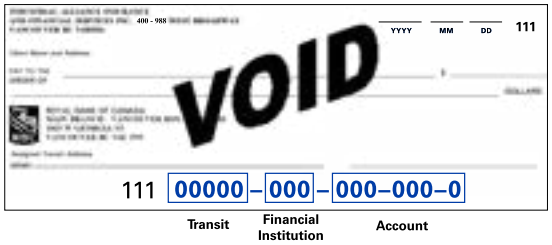
Withdrawal Arrangement
◯ Fixed ⊗ Variable

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

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)

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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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