Professional Pilot Insurance Plan

YOUR GROUP BENEFITS

www.ppip.ca
ppip@rbiadvisory.com

Professional Pilot Insurance Plan

GROUP POLICY NUMBER
1 0 0 0 0 7 5 2 1

BENEFITS SUMMARY

Please print in ink

ELIGIBILITY

Available to pilots under age 65, who are residents of Canada and hold a valid Canadian Airline Transport Pilot Licence (ATPL), or Commercial Pilot Licence (CPL) and a valid medical certificate (Cat. 1)

BENEFITS AVAILABLE

Optional Group Term Life Insurance

- Available to both you and your spouse
- Can be purchased in units of $50,000 to a maximum amount of $500,000
- Premiums for Optional Group Term Life Insurance are based on the gender, age and smoker status of the person applying, and on the amount of insurance.
- Premiums are paid monthly by Pre-Authorized Debit (PAD)
- Coverage is available to age 70

Dependent Term Life Insurance

- Coverage is mandatory for Pilot Members selecting "family coverage"
- Covers your spouse and your dependent children for $5,000 each in the event of death
- Coverage is available to age 70 for spouses

Accidental Death, Disease and Dismemberment Insurance (AD, D&D)

- Available to Pilots only who are insured for Optional Group Term Life Insurance
- Includes a provision for accidental loss if the incident occurs when performing the duties of your occupation as required by your employer.
- Pays an equal amount to the sum insured under the life benefit in the event of an accidental death
- Pays a portion of the death benefit for dismemberment, loss of use or paralysis due to an accident
- Optional Group Term Life Insurance must be elected prior to having AD, D&D Insurance coverage
- Coverage is available to age 70

Best Doctors

- Service provides seriously injured or ill pilots (including eligible spouse and dependents) access to technologies and medical opinions of world-class medical specialists
- Is the world leader in connecting people with the best medical care
- Coverage is available to age 70

GENERAL QUESTIONS

Can my spouse apply for additional coverage?

- Yes, your spouse can apply for additional optional life insurance at any time. The application for coverage is medically underwritten and must be approved prior to coverage taking effect (see attached application). Once the application is approved, premiums will be due on the 1st of the month following approval
- For Spousal coverage, the beneficiary will automatically be designated the Pilot Member

Who qualifies as a dependent?

- The professional Pilot Member's legal spouse, common-law spouse or former spouse. The same person must be insured for all spousal benefits and only one spouse can be insured at a time
- Common-law spouse is a person who has been cohabiting in a marriage-like relationship with the Pilot Member for a period of not less than twelve consecutive months
- Dependent Children means any natural child, step-child or legally adopted child of a Pilot Member and/or a Spouse or any other children for whom the Pilot Member or Spouse has been appointed legal guardian who lives with the Pilot Member and Spouse who is over 14 days of age and under 21 years of age, unmarried and receives full parental support and maintenance; or 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. Mentally and physically disabled children may remain covered beyond 21 years provided they are incapable of self-sustaining employment and receive full parental support and maintenance

Why do I need additional coverage?

- Statistics indicate that Canadian families require insurance coverage at a level of at least 4 to 6 times the annual household income. One of the most valuable assets that we as individuals possess is the ability to earn income. Loss of income through untimely death can have a devastating effect on a family's lifestyle and dreams unless provisions are made for the replacement of lost income

Is a medical exam required for the Pilot Member?

- No medical exam is required if the Pilot Member holds a valid Canadian Airline Transport License (ATPL) or Commercial Pilot Licence (CPL) and a valid medical certificate (Cat. 1)

When does my coverage reduce or terminate?

- Your coverage amount will reduce by 50% at age 60 to a maximum benefit amount of $250,000. Coverage will terminate at age 70

Can I convert the coverage?

- The Pilot Member and spouse may convert his/her life insurance to an individual insurance plan without providing evidence of insurability if their situation changes so that the Pilot Member or spouse ceases to be eligible on or before age 65.

PLEASE SEND YOUR COMPLETED FORM TO:

Professional Pilot Insurance Plan
Box 89, Station Main, Okotoks, AB T1S 1A4

Contact us toll-free at **1-888-724-1444**
Monday to Friday from 8:30 to 16:30 (Mountain Time)
or email **ppip@rbiadvisory.com**

This is a summary of the principal features of the Professional Pilot Insurance Plan, but the Group Master Policy 100007521 issued by Industrial Alliance Insurance and Financial Services Inc. is the governing document. In the event of any variation between the information in this summary and the provision of the Group Master Policy, the latter will prevail.

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OPTIONAL GROUP INSURANCE PILOT MEMBER APPLICATION & CHANGE FORM

Please print in ink

PILOT MEMBER INFORMATION THIS SECTION MUST ALWAYS BE COMPLETE

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

○ Male ○ Female

Pilot Licence Number | Marital Status

○ Single ○ Family

Street Address | City | Prov. | Postal Code

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

INSURANCE INFORMATION DO NOT INCLUDE ANY COVERAGE ALREADY IN FORCE UNDER THIS PLAN

○ **Pilot Member Optional Term Life Insurance**
Select amount of coverage desired

○ **$50,000**	○ **$200,000**	○ **$350,000**
○ **$100,000**	○ **$250,000**	○ **$400,000**
○ **$150,000**	○ **$300,000**	○ **$450,000**
		○ **$500,000**

○ **Accidental Death, Disease & Dismemberment Insurance**
Available only to Pilot Members insured for Optional Term LIfe Insurance, Amount of coverage will be equivalent to Pilot Member Optional Term Life Insurances Amount.

○ **Dependent Term Life Insurance**
Dependents of Pilot Members who select "family coverage" are automatically covered for $5,000 of Dependent Term Life Insurance per spouse and/or child

Specify number of eligible children

Name of spouse

HEALTH AND LIFESTYLE QUESTIONS

Pilot Members – Attach photocopies of both sides of your valid Canadian Airline Transport Pilot Licence (ATPL) or Commercial Pilot Licence (CPL) and your valid Medical Certificate (CAT.1)		**Pilot Member**	
		Yes	No
1)	Have you used any form of tobacco (except an average of one cigar a month), including nicotine products, electronic cigarettes, marijuana mixed with tobacco, hashish mixed with tobacco, smoking cessation products, betel nuts or leaves, supari, paan, gutka or shisha, within the last 12 months?	☐	☐
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 free from any condition that could possibly prevent you from passing your Transport Canada medical?	☐	☐
3)	Are you a resident of Canada?	☐	☐

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BENEFICIARY DESIGNATION

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 Pilot Member's death to benefits payable under the Pilot Member Optional Group 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 Pilot Member	% Payable to each
Beneficiary Last Name	Beneficiary Given Name	Relationship to Pilot 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 Pilot Member is the beneficiary for the dependent children Term Life benefit.

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

DECLARATION AND AUTHORIZATION FORM MUST BE SIGNED IN INK

I acknowledge that all correspondence relating to this application 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 Professional Pilot Insurance Plan ("PPIP") at the telephone number or address shown on this application.

I confirm that the foregoing answers, forming part of an application for group insurance under the Professional Pilot Insurance Plan ("PPIP") and underwritten by Industrial Alliance Insurance and Financial Services Inc. 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 PPIP 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 plan administrator and the first month's premium has been paid.

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

X _____ _____

Signature of Pilot Member (must always sign) | Date (dd-mmm-yyyy)

PLEASE SEND YOUR COMPLETED FORM TO:

Professional Pilot Insurance Plan
Box 89, Station Main, Okotoks, AB T1S 1A4

Contact us toll-free at **1-888-724-1444**
Monday to Friday from 8:30 to 16:30 (Mountain Time)
or email **ppip@rbiadvisory.com**

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PRE-AUTHORIZED DEBIT (PAD) AGREEMENT

Please complete, print and sign

PILOT MEMBER INFORMATION

Last Name	Given Name	Initials	Member/Employee ID

STEP 1 - PROVIDE DETAILS FOR MONTHLY PRE-AUTHORIZED DEBITS

ATTACH A PERSONALIZED 'VOID' CHEQUE OR COMPLETE THE INFORMATION BELOW

ACCOUNT DETAILS

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

Financial Institution Number	Transit Number	Account Number

WITHDRAWAL ARRANGEMENT

○ Fixed ☑ Variable

STEP 2 - REVIEW AND PROVIDE AUTHORIZATION

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.cdnpay.ca.

AUTHORIZATION FORM MUST BE SIGNED IN INK

I/we, as the Account Holder(s), authorize Professional Pilot Insurance Plan ('PPIP') 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 PPIP 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. I/we agree that PPIP will provide written notice of the amount of the PAD at least three (3) calendar days before the first PAD is debited and before any increase to the PAD amount is debited, except when the increase is due to a change in sales taxes, or the increase to the PAD amount is a result of my/our request.

I/we may cancel this PAD Agreement at any time, subject to providing notice to PPIP 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.cdnpay.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	
Pilot 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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OPTIONAL GROUP INSURANCE SPOUSE APPLICATION & CHANGE FORM

Please print in ink

PILOT MEMBER INFORMATION THIS SECTION MUST ALWAYS BE COMPLETE

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

Pilot Licence Number

SPOUSE INFORMATION

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

Place of Birth | Occupation

Street Address | City | Prov. | Postal Code

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

INSURANCE INFORMATION INCLUDE ANY COVERAGE THAT IS ALREADY IN FORCE UNDER THIS GROUP PLAN

○ **Spouse Optional Group Term Life Insurance**
Select amount of coverage desired

- ○ **$50,000**
- ○ **$100,000**
- ○ **$150,000**
- ○ **$200,000**
- ○ **$250,000**
- ○ **$300,000**
- ○ **$350,000**
- ○ **$400,000**
- ○ **$450,000**
- ○ **$500,000**

BENEFICIARY DESIGNATION

Unless otherwise stated in writing, the Pilot Member is the beneficiary for the Spouse Optional Group Term Life Insurance.

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

If you answer "Yes" to any question below (or "No" to question 6), please complete the Additional Details section below.

		Spouse Yes	Spouse No
Spouse:	**Height:** ☐ ○ ft/in ○ cm **Weight:** ☐ ○ lbs ○ kgs		
1)	Have you used any form of tobacco (except an average of one cigar a month), including nicotine products, electronic cigarettes, marijuana mixed with tobacco, hashish mixed with tobacco, smoking cessation products, betel nuts or leaves, supari, paan, gutka or shisha, within the last 12 months? If "Yes", indicate product used and provide details below.	☐	☐
2)	Have you flown as a pilot, student or crew member in the last two years or do you have any intention to do so?	☐	☐
3)	Have you engaged in or do you intend to participate in scuba diving, parachuting or other hazardous sport or activity?	☐	☐
4)	Do you intend to travel or reside outside Canada or the United States for more than a month?	☐	☐
5)	Have you had a request for life, disability or critical illness insurance declined, postponed, rated or modified in any way?	☐	☐
6)	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.	☐	☐
7)	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?	☐	☐
8)	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?	☐	☐
9)	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?	☐	☐
10)	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?	☐	☐
11)	Have you ever used marijuana, heroin, morphine, cocaine, LSD, barbiturates, amphetamines, or any other drug or narcotic, except as prescribed by your physician?	☐	☐
12)	a) Do you presently drink more than 12 alcoholic beverages per week? If "Yes", state number, kind and frequency consumed.	☐	☐
	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?	☐	☐
13)	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?	☐	☐
14)	Are you taking any prescribed medication? If "Yes", state name of medication and reason for use.	☐	☐
15)	Are you aware of any symptoms or complaints regarding your health for which you have not yet consulted a physician or received treatment?	☐	☐
16)	Have you been absent from work for more than seven consecutive days within the past year due to sickness or injury?	☐	☐
17)	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.	☐	☐
18)	Females only: Are you currently pregnant? If "Yes", please provide your estimated due date and advise of any complications with current or past pregnancies.	☐	☐
19)	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?	☐	☐
20)	Have you ever received or claimed benefits or a pension for sickness, injury or impairment?	☐	☐
21)	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?	☐	☐
22)	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?	☐	☐

ADDITIONAL DETAILS IF ANY OF QUESTIONS 1-22 ARE ANSWERED "YES", OR "NO" TO QUESTION 6, PROVIDE DETAILS BELOW

Question Number	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.

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1 0 0 0 0 7 5 2 1

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 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 PPIP 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 approval of my properly completed application has been communicated by the Company to the group administrator and the first month's premium has been paid.

I understand that the same payment instructions applicable to the Pilot Members Insurance coverage under PPIP will apply to premiums due for Spouse Optional Group Term Life Insurance, unless new instructions are attached.

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

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

This form must be received in our office within 60 days of the date signed otherwise a new application must be completed.

PLEASE SEND YOUR COMPLETED FORM TO:

Professional Pilot Insurance Plan
Box 89, Station Main, Okotoks, AB T1S 1A4

Contact us toll-free at **1-888-724-1444**
Monday to Friday from 8:30 to 16:30 (Mountain Time)
or email **ppip@rbiadvisory.com**

PLAN RATES

OPTIONAL GROUP TERM LIFE INSURANCE

- Available to Pilot Member and Spouse
- Units of $50,000 to maximum of $500,000
- Monthly rates per $50,000 of insurance
- Maximum coverage available between ages 60 to 69 is $250,000
- Non-smoker rates available if you have not used tobacco products in the past 12 months

MONTHLY PREMIUMS PER $50,000 UNIT OF INSURANCE

	Non-Smoker*		Smoker	
Age	Male	Female	Male	Female
Under 35	$4.00	$3.30	$6.56	$5.30
35-39	$4.50	$3.86	$8.80	$7.60
40-44	$5.96	$3.86	$13.36	$9.10
45-49	$8.46	$5.56	$19.06	$13.00
50-54	$12.46	$7.86	$24.66	$16.26
55-59	$18.90	$12.00	$39.46	$24.20
60-64	$31.80	$22.50	$58.00	$36.60
65-69	$58.30	$39.40	$98.00	$55.70
70	Coverage Terminates			

* Non-smoker rates apply to individuals who, at the time of application, have not used any form of tobacco (except an average of one cigar a month), including nicotine products, electronic cigarettes, marijuana mixed with tobacco, hashish mixed with tobacco, smoking cessation products, betel nuts or leaves, supari, paan, gutka or shisha, within the last 12 months and who have provided satisfactory evidence of insurability.

ACCIDENTAL DEATH, DISEASE & DISMEMBERMENT INSURANCE NON-OCCUPATIONAL

- Units of $50,000 to maximum of $500,000
- Coverage is available only to Pilots
- Amount of AD,D&D Insurance must be equal to the amount of Pilot Member Optional Group Term Life Insurance coverage selected
- An amount equal to 25% of your Optional Group Life insurance for death/ accidental injuries occurring while the Plan Member is performing their duties of occupation as required by their employer to a maximum benefit of $75,000.

MONTHLY PREMIUM

Coverage	Monthly
$50,000	$2.25
$100,000	$4.50
$150,000	$6.75
$200,000	$9.00
$250,000	$11.25
$300,000	$13.50
$350,000	$15.75
$400,000	$18.00
$450,000	$20.25
$500,000	$22.50

DEPENDENT TERM LIFE INSURANCE

- Coverage is mandatory for Pilot Members selecting "family coverage"
- Provides $5,000 of life insurance per eligible Dependent (spouse and/or child)
- Monthly rate is $1.90 per family

BEST DOCTORS SERVICES

- Coverage is mandatory for all Pilot Members
- Monthly rate is $1.35 per month

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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: 2165 West Broadway. P.O. Box 5900, Vancouver, BC V6B 5H6, Attention: Director, Special Markets Solutions. 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.

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.

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iA Financial Group

Special Markets Solutions
Industrial Alliance Insurance and Financial Services Inc.
2165 Broadway W, PO Box 5900, Vancouver, BC V6B 5H6

Application Made Easy

Simply complete the enclosed application form and mail to:

Professional Pilot Insurance Plan
Box 89, Station Main
Okotoks AB T1S 1A4

Pilot Members please remember to send in a copy of your valid Canadian Airline Transport Pilot Licence (ATPL) or Commercial Pilot Licence (CPL) and a valid medical certificate (Cat 1)

For questions and inquiries regarding your Insurance Plan:

Call Toll Free: 1-888-724-1444 (8:30 to 16:30 Mountain Time, Monday to Friday) or
Email: ppip@rbiadvisory.com or visit our website at www.ppip.ca
Fax: (403) 938 0232