INDUSTRIAL ALLIANCE
INSURANCE AND FINANCIAL SERVICES INC.

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SUPPLEMENTAL QUESTIONNAIRE FOR DEPENDENT CHILD INSURANCE

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

Name of Policyholder

Group Policy No.

MEMBER/EMPLOYEE INFORMATION

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

○ M ○ F

Street Address | City | Prov. | Postal Code

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

INSURANCE INFORMATION

Type of insurance requested

Total amount of insurance requested

$

Type of insurance requested

Total amount of insurance requested

$

DEPENDENT CHILD INFORMATION

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

○ M ○ F

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 ○ ft/in ○ cm

Weight ○ lbs ○ kgs

Name of Education Institution

1. Has there been a weight loss or gain or 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? ○ lbs ○ kgs

Was this a gain or a loss? ○ Gain ○ Loss

Reason

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.

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

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FAMILY HISTORY QUESTION

Have any of the Dependent Child's biological parents, grandparents, brothers or sisters ever suffered from any of the following conditions: Heart attack, angina, bypass surgery 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, 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:

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 my dependent child's health, to give to Industrial Alliance Insurance and Financial Services Inc. or its reinsurers any such information for the purpose of the risk assessment, administration or investigation of a subsequent claim.

b) Industrial Alliance 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) Industrial Alliance 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.

d) Industrial Alliance to release any abnormal test results to my dependent child's 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 Member/Employee.

I further acknowledge receipt of the Notice on Privacy and Confidentiality (attached) summarizing certain privacy practices regarding collection, use and disclosure of my and my dependent child's personal information.

I confirm that the foregoing answers, forming part of an application for group insurance to 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 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 Industrial Alliance of any change in my dependent child's health or insurability. I agree that insurance will not take effect until my properly completed application has been approved by Industrial Alliance and the first month's premium has been paid.

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

X

Member/Employee Signature
(must always sign)

Date (dd-mmm-yyyy)

X

Dependent Signature
(if 18 or older)

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. employees, its reinsurers, third party administrators, mandataries, agents or brokers of Industrial Alliance, plan sponsors and any agents or brokers of such sponsors or other market intermediaries who are responsible for (a) sponsoring a plan for you, (b) marketing and administration of products or services, (c) assessment of risk (underwriting) and (d) investigation of claims. **Your file will be kept in Industrial Alliance's 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, Administration, 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 at our website www.inalco.com 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. 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.

Industrial Alliance 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.

PLEASE SEND YOUR COMPLETED FORM TO:

SPECIAL MARKETS solutions

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

QUESTIONS?

Contact us toll-free at **1.800.266.5667**
Monday to Friday from 6:30 AM to 4:30 PM PT
or by email at **solutions@inalco.com**