Identification no.

VOID

F3A

ADDITION OF COVERAGE

VOID

Client name(s)

ia.ca

TABLE OF CONTENTS

	Section	Description
Mandatory at all times	1	Proposed insured
	2	Insurance history
Universal life insurance	3	GENESIS
Specialized life insurance	4	LEGACY
Participating life insurance	5	iA PAR
Whole life and term insurance	6	TRADITIONAL INSURANCE
Critical illness insurance	7	TRANSITION 25 Illnesses - TRANSITION 4 Illnesses
Benefits	8	Additional Benefits
Beneficiaries – life insurance and critical illness	9	Beneficiaries
Mandatory at all times	10	Risk class for term life contracts or riders for $2,000,001 or more
	11	Eligibility
	[illegible]	[illegible]ts
	[illegible]	Produ[illegible]
	[illegible]4	Declaration[illegible]rability
	15	Additional qu[illegible]ires
	16	Signatures a[illegible]rization
	17	Authorization[illegible]
Give [illegible]	18	Pre-notice fr[illegible]LLC
Appen[illegible]	[illegible]19	Medical co[illegible] & non-me[illegible]nditions [illegible]tional questionna[illegible]

VOID

Additional [illegible]ts to provide (if applicab[illegible]

☐ Mandatory illustration for GENESIS, LEGACY and iA PAR

☐ F6A or F4A form for a total or partial surrender

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F3A

POLICY NO. (for internal use)

Identification no.

VOID

1 PROPOSED INSURED *(Write legibly in block letters.)*

A Identification

Last name | First name | Middle name

If your name has changed, what was your full name at birth?

Sex ☐ M ☐ F

Date of birth Y Y Y Y M M D D

Language ☐ English ☐ French

Social Insurance Number – Optional

Relationship to applicant

At issue, the policy will be established based on the insured's age as of his or her nearest birthday, unless you wish to save the insured's actual age.

If you wi[illegible] the insured's actual [illegible]cate the age to save: [illegible]
The policy [illegible]miums will be establ[illegible]sed on the indi[illegible] applicable und[illegible] rules and [illegible] premiums.

For Genesi[illegible] and iA PAR po[illegible]ly (to be co[illegible]ly if the insure[illegible]he applican[illegible]

Main occupat[illegible]pecific, terms [illegible] "manager" [illegible]ufficient):

Name of employ[illegible]

VOID

B Address

⚠ **Always manda[illegible] possible to provid[illegible] address, please [illegible]opy of an [illegible]tion docu[illegible]th proof of addre[illegible]**

No. | Stre[illegible] | [illegible]ent/Office/Unit

City | Province | Postal code

Station – Optional | Rural route | P.O. Box

C Contact

Home phone | Cell phone

Work phone | Extension | Email

D Confirmation of identity - For Genesis, Legacy and iA PAR policies only

To be completed only if the insured is also the applicant. Refer to an authentic and unexpired piece of government-issued PHOTO identification.

Type of document | Document number

Place of issue | Expiry date (if applicable) Y Y Y Y M M D D

2 INSURANCE HISTORY

A Pending insurance

Do you have other pending insurance applications? ☐ YES ☐ NO

If YES, considering all your pending insurance applications with all insurance companies (including iA Financial Group), what is the total amount you plan on buying?

Main insured

Amount of life insurance	Amount of critical illness insurance	Amount of disability insurance
$	$	$

B Declined insurance

Have you ever been declined for insurance? ☐ YES ☐ NO

If YES, please provide the following information:

Main insured

Year	Reason(s)	Life	Critical illness	Disability
Y Y Y Y		☐	☐	☐
Y Y Y Y		☐	☐	☐
Y Y Y Y		☐	☐	☐

C Insurance

Do you hav insurance on yo cluding gro or credit insu ☐ YES ☐ NO

If YES, please the following i on:

Main insured

Name of comp	Surrender contract?	y number ontract)	li ce	of c ness ce	of y e	Year of issue	Need
	☐ Yes* ☐ No			$	$	Y Y	☐ Personal ☐ Business
	☐ Yes* ☐ No		$	$	$	Y Y	☐ Personal ☐ Business
	☐ Yes* ☐ No		$	$	$	Y Y Y Y	☐ Personal ☐ Business

*Please attach all required documents: Replacement/disclosure form (if applicable) and/or iA Financial Group surrender form (F6A or F4A-04).

VOID

Identification no.

VOID

REQUESTED COVERAGE

3 GENESIS (Attention – Complete beneficiary section on pages 7 and 8.)

GENESIS ⚠ **For Genesis, provide the current version of the complete illustration signed by the client. An insured cannot be added to a universal policy except for a joint coverage application.**

Permanent Life Coverage

$

Term Life Coverage Rider

T10 R & C $

T20 R & C $

Pick-A-Term T25 $

Pick-A-Term T30 $

Critical Illness – 25 Illnesses Rider

T10 R & C $

T20 R & C $

T25 R & C $

T75 $

T100 $

Critical Illness – 4 Illnesses Rider

T10 R & C* $ ☐ Level ☐ Decreasing 50%

T20 R & C* $ ☐ Level ☐ Decreasing 50%

T25 R & C* $ ☐ Level ☐ Decreasing 50%

T75 $

T100 $

* If no indication is provided, the Level face amount option will apply by default.

Disability Credit Rider ⟶ Please complete questions 11.B.1.

Insurance Needs $ /month

As p[illegible]ds Analysis

Benefit Chosen $ /month

Min. $300, max. $[illegible]

Benefit Du[illegible]

☐ 2 years ☐ [illegible] years ☐ To[illegible]

Supplementary Income Rider (SI) ⟶ Please complete questions 11.B.

Amount of the SI benefit: $ /month

(min. $100, max. $2,000 without exceeding the eligible

Durat[illegible]efit: ☐ [illegible] ☐ [illegible] age

Type [illegible]e: ☐ [illegible] and illness

☐ [illegible] only (No benefit is paya[illegible] [illegible]lity caused by an illness[illegible]

Cost of insuran[illegible]

☐ Annual (YRT) [illegible]ng of the cost of [illegible] is planned after ____ [illegible]rs. This i[illegible] automatic [illegible]d must be requeste[illegible] [illegible]pplicant.

☐ Level only (with n[illegible] [illegible]ent option)

☐ Level – **Quick payment option** ☐ 10 years ☐ 15 years ☐ 20 years

⚠ **On the applicant ⟶ Please indicate your occupation (section 11.A.3) and complete the *Declarations of Insurability* section.**

Contribution in the event of **applicant's** disability (CAD) $ /month

or ☐ CAD = reference premium*

Contribution in the event of **applicant's** death (CADE) $ /month

or ☐ CADE = reference premium*

Contribution in the event of **insured's** disability (CID) $ /month

If the applicant is a company.

* Minimum premium (for universal life type coverage prior to Genesis 9)

VOID

Identification no.

VOID

REQUESTED COVERAGE

4 LEGACY (Attention – Complete beneficiary section on page 7.)

FOR A JOINT COVERAGE (LAST TO DIE) OR AN ADDITION OF RIDER.

LEGACY **For Legacy, provide the current version of the complete illustration signed by the client. For an addition of Legacy permanent coverage, complete an application for Life and Critical Illness insurance (form F1A).**

Base Coverage

$

Term Life Coverage Rider

T10 R & C $

T20 R & C $

Pick-A-Term T25 $

Pick-A-Term T30 $

On the applicant ⟶ Please indicate your occupation (section 11.A.3) and complete the *Declarations of Insurability* section.

Contribution in the event of **applicant's** disability (CAD) $ /month

or ☐ CAD = current premium

Contribution in the event of **applicant's** death (CADE) $ /month

or ☐ CADE = current premium

Contribution in the event of **insured's** disability (CID) $ /month

If the applicant is a company.

5 iA PAR (Attention – Complete beneficiary section on pages 7 and 8.)

FOR A JOINT COVERAGE (LAST TO DIE) OR AN ADDITION OF RIDER.

iA PA[illegible] **For iA PAR, provide t[illegible]nt version of the c[illegible]tion signed by the cli[illegible]n additio[illegible] coverage, [illegible]omplete an applica[illegible] Life and Critic[illegible]F1A).**

Base cove[illegible] premium pay[illegible]ation

$ Payab[illegible] 100

[illegible]yment

$ 20-Year P[illegible]

Term Life Cove[illegible]er

T10 R & C

T20 R & C

Pick-A-Term T25 $

Pick-A-Term T30 $

C[illegible]ness – 25 Illnesses Rider

T1[illegible] $

T20 R[illegible]

T25 R & C

T75 $

T100 $

Criti[illegible] – 4 Illne[illegible]er

T10 [illegible] ☐ Level [illegible]sing 50%

T20 [illegible] [illegible]reasing 50%

T25 [illegible] ☐ Decreasing 50%

T75 $

T100 $

* If no indication is provided, the Level face amount option will apply by default.

Disability Credit Rider ⟶ Please complete questions 17.B.1.

Insurance Needs

$ /month

As per the Needs Analysis

Benefit Chosen

$ /month

Min. $300, max. $3,500

Benefit Duration

☐ 2 years ☐ 5 years ☐ To age 65

VOID

Identification no.

VOID

REQUESTED COVERAGE

6 TRADITIONAL INSURANCE (Attention – Complete beneficiary section on pages 7 and 8.)

Whole Life Coverage

L10 $

L20 $

L65 $

L100 $

T100 $

Life and Serenity 65 $

The Q9A Preselection questionnaire must be completed.

Child Life & Health Duo $

Term Life Coverage

T10 R & C $

T20 R & C $

Pick-A-Term $

Term (Between 10 and 40 years)

Selected Option*: ☐ Level ☐ Decreasing 50%

Critical Illness – 25 Illnesses Rider

T10 R & C $

T20 R & C $

T25 R & C $

T75 $

T100 $

Critical Illness – 4 Illnesses Rider

T10 R & C* $ ☐ Level ☐ Decreasing 50%

T20 R & C* $ ☐ Level ☐ Decreasing 50%

T25 R & C* $ ☐ Level ☐ Decreasing 50%

T75 $

T100 $

* If no indication is provided, the Level face amount option will apply by default.

Disabili... Rider ⟶ Please com... questions 11.B.1.

Insuranc... ...efit Chosen

$ /month $ ...onth

As per t... ...nalysis   Min. $... ...3,500

Benefit Durat...

☐ 2 years ☐ ...rs ☐ ...65

Supplementary I... Rider (SI) ⟶ ... questions 11.B.

...ount of the SI b... $

(min. $... $2,000 without e... ...e eligible benef... ...1.B.2)

...of benefi... ...ears ☐ ...65

...verage: ...cident and...

...cident onl... ...fit is payable ...a disability... ...an illness.)

VOID

7 TRANSITION (Att... ...mplete beneficiary...

TRANSITION 25 I...ES

ROPD: Return of Premiums upon Death	FRP 15: Flexible Return of Premiums, 100% after 15 years*	FRP 65: Flexible Return of Premiums, 100% at 65 years old (available up to 49 years, insurance age)	FRP 20: Flexible Return of Premiums, 100% after 20 years

T10 R & C $ ☐ ROPD

T20 R & C $ ☐ ROPD

T25 R & C $ ☐ ROPD

T75 $ ☐ ROPD ☐ FRP 15 or ☐ FRP 65

T100 $ ☐ ROPD ☐ FRP 15 or ☐ FRP 65

T100 10-Year Payment $ ☐ ROPD ☐ FRP 20

T100 20-Year Payment $ ☐ ROPD ☐ FRP 20

* Available up to 60 years for the T75; available up to 65 years for the T100 (insurance age)

☐ Increased Benefit Rider

Supplementary Income Rider (SI) ⟶ Please complete questions 11.B.

Amount of the SI benefit: $ /month (min. $100, max. $2,000 without exceeding the eligible benefit, section 11.B.2)

Duration of benefit: ☐ 2 years ☐ To age 65

Type of coverage: ☐ Accident and illness ☐ Accident only (No benefit is payable for a disability caused by an illness.)

Transition Child $

Complete the F3A Addition of Coverage form.

On the applicant ⟶ Please indicate your occupation (section 11.A.3) and complete the *Declarations of Insurability* section. ☐ WPDis for life

Identification no.

VOID

REQUESTED COVERAGE

TRANSITION 4 ILLNESSES

ROPD: Return of Premiums upon Death	FRP 15: Flexible Return of Premiums, 100% after 15 years*	FRP 65: Flexible Return of Premiums, 100% at 65 years old (available up to 49 years, insurance age)	FRP 20: Flexible Return of Premiums, 100% after 20 years

Coverage	Amount	Option
T10 R & C Level	$	☐ ROPD
T10 R & C Decreasing 50%	$	☐ ROPD
T20 R & C Level	$	☐ ROPD
T20 R & C Decreasing 50%	$	☐ ROPD
T25 R & C Level	$	☐ ROPD
T25 R & C Decreasing 50%	$	☐ ROPD

Coverage	Amount	Option	Option
T75	$	☐ ROPD	☐ FRP 15 or ☐ FRP 65
T100	$	☐ ROPD	☐ FRP 15 or ☐ FRP 65
T100 10-Year Payment	$	☐ ROPD	☐ FRP 20
T100 20-Year Payment	$	☐ ROPD	☐ FRP 20

* Available up to 60 years for the T75; available up to 65 years for the T100 (insurance age)

☐ Increased Benefit Rider

Supplementary Income Rider (SI) ⟶ Please complete questions 11.B.

Amount of the SI benefit: $ /month (min. $ $2,000 without exceeding t benefit, section 1

Duration of benefit: ☐ 2 years ☐ To age 65

Type of co ☐ Accident an ☐ Accid benefit is payable for a used by an illness.)

Transition Ch ⚠ e the F3A Addition of Covera

⚠ **On the applica ease your occupati n 11.A.3) and complete t *ations o ility* sectio** WPDis for life

8 ADDITIONAL BE

On the applicant ⟶ icate your occupation (section the *Declarations o ility* sectio

☐ Waiver of premiums in case of the applicant's disability (WPDis)
☐ Waiver of premiums in case of the applicant's death (WPD)
☐ Waiver of premiums in case of the insured's disability (WP) ⟶ **If the applicant is a company.**

☐ Accidental fracture (AF)
☐ Accidental death (AD) $
☐ Accidental death and dismemberment (AD&D) $
☐ Guaranteed insurability (GI) $

☐ Paramedical care
☐ Hospitalization $
☐ Hospitalization and home care $

CHILD MODULE

⚠ **For each child, complete the Addition of Coverage form F3A. The Child Module or Child Module PLUS cannot be added to a contract issued prior to January 1, 2017. Do not designate a beneficiary for child module, module PLUS or critical illness coverage.**

Number of born children to be covered: ___________

☐ Child module $
☐ Child module PLUS $
☐ Child critical illness $

VOID

9 BENEFICIARIES

BENEFICIARY – LIFE INSURANCE

The lack of designation constitutes a revocable designation in favour of the applicant (in equal parts if more than one applicant), if different from the insured.
Do not designate a beneficiary for child module or module PLUS coverage.

Beneficiary 1

Last name ______ First name ______

Sex: ☐ M ☐ F Date of birth Y Y Y Y M M D D Relationship to proposed insured ______ % ______ ☐ Revocable ☐ Irrevocable

Contingent beneficiary 1 (last name, first name)	Contingent beneficiary 2 (last name, first name)
Sex ☐ M ☐ F ☐ Revocable ☐ Irrevocable	Sex ☐ M ☐ F ☐ Revocable ☐ Irrevocable
Date of birth Y Y Y Y M M D D %	Date of birth Y Y Y Y M M D D %
Relationship to proposed insured	Relationship to proposed insured

Beneficiary 2

Last name ______ First name ______

Sex: ☐ M ☐ F Date of birth Y Y Y Y M M D D Relationship to proposed insured ______ % ______ ☐ Revocable ☐ Irrevocable

Contingent beneficiary 1 (last name, first name)	Contingent beneficiary 2 (last name, first name)
Sex ☐ M ☐ F ☐ Revocable ☐ Irrevocable	Sex ☐ M ☐ F ☐ Revocable ☐ Irrevocable
Date of birth Y Y Y Y M M D D %	Date of birth Y Y Y Y M M D D %
Relationship to proposed insured	Relationship to proposed insured

Beneficiary 3

Last name ______ First name ______

Sex: ☐ M ☐ F Date of birth Y Y Y Y M M D D Relationship to proposed insured ______ % ______ ☐ Revocable ☐ Irrevocable

Contingent beneficiary 1 (last name, first name)	Contingent beneficiary 2 (last name, first name)
Sex ☐ M ☐ F ☐ Revocable ☐ Irrevocable	Sex ☐ M ☐ F ☐ Revocable ☐ Irrevocable
Date of birth Y Y Y Y M M D D %	Date of birth Y Y Y Y M M D D %
Relationship to proposed insured	Relationship to proposed insured

Beneficiary 4

Last name ______ First name ______

Sex: ☐ M ☐ F Date of birth Y Y Y Y M M D D Relationship to proposed insured ______ % ______ ☐ Revocable ☐ Irrevocable

Contingent beneficiary 1 (last name, first name)	Contingent beneficiary 2 (last name, first name)
Sex ☐ M ☐ F ☐ Revocable ☐ Irrevocable	Sex ☐ M ☐ F ☐ Revocable ☐ Irrevocable
Date of birth Y Y Y Y M M D D %	Date of birth Y Y Y Y M M D D %
Relationship to proposed insured	Relationship to proposed insured

VOID

BENEFICIARY – CRITICAL ILLNESS

The lack of designation constitutes a revocable designation in favour of the applicant (in equal parts if more than one applicant).
Do not designate a beneficiary for child critical illness coverage.

1. Benefits in the event of critical illness

☐ Applicant(s) - in equal parts if applicable **OR** ☐ Insured **OR**

Beneficiary 1

Last name ______ First name ______

Sex ☐ M ☐ F | Date of birth Y Y Y Y M M D D | Relationship to proposed insured ______ | % ______ | ☐ Revocable ☐ Irrevocable

Contingent beneficiary 1 (last name, first name)	Contingent beneficiary 2 (last name, first name)
Sex ☐ M ☐ F ☐ Revocable ☐ Irrevocable %	Sex ☐ M ☐ F ☐ Revocable ☐ Irrevocable %
Date of birth Y Y Y Y M M D D	Date of birth Y Y Y Y M M D D
Relationship to proposed insured	Relationship to proposed insured

Beneficiary 2

Last name ______ First name ______

Sex ☐ M ☐ F | Date of birth Y Y Y Y M M D D | Relationship to proposed insured ______ | % ______ | ☐ Revocable ☐ Irrevocable

Contingent beneficiary 1 (last name, first name)	Contingent beneficiary 2 (last name, first name)
Sex ☐ M ☐ F ☐ Revocable ☐ Irrevocable %	Sex ☐ M ☐ F ☐ Revocable ☐ Irrevocable %
Date of birth Y Y Y Y M M D D	Date of birth Y Y Y Y M M D D
Relationship to proposed insured	Relationship to proposed insured

2. Return of premiums at death

Last name ______ First name ______

Sex ☐ M ☐ F | Date of birth Y Y Y Y M M D D | Relationship to proposed insured ______ | % ______ | ☐ Revocable ☐ Irrevocable

Last name ______ First name ______

Sex ☐ M ☐ F | Date of birth Y Y Y Y M M D D | Relationship to proposed insured ______ | % ______ | ☐ Revocable ☐ Irrevocable

3. Flexible return of premiums during the insured's lifetime

☐ Applicant(s) - in equal parts if applicable **OR** ☐ Insured → ☐ Revocable ☐ Irrevocable

TRUSTEE* (if beneficiary is under age 18)

Last name, first name ______ | Sex ☐ M ☐ F | Date of birth Y Y Y Y M M D D | Relationship to proposed insured ______

* A trustee should be named for any minor beneficiaries or for any beneficiary who cannot give a valid discharge.
I name the above-mentioned person trustee to receive benefits payable in the name of any beneficiary who has not reached legal age or who does not have the legal capacity to discharge.
This designation is revocable and applies until the beneficiary named below reaches legal age.

THE DESIGNATION OF A TRUSTEE IS NOT APPLICABLE IN QUEBEC.
Any amount payable to a minor beneficiary will be paid on his/her behalf to the parent(s) or the legal guardian.

For beneficiary – Last name, first name ______ **For beneficiary –** Last name, first name ______

10 RISK CLASS FOR TERM LIFE CONTRACTS OR RIDERS FOR $2,000,001 OR MORE

If preferred underwriting can be granted: ☐ Reduce the premium ☐ Increase the face amount

If no instructions are given, the premium will be reduced.

VOID

Identification no.

VOID

11 ELIGIBILITY

A Eligibility

1) Tobacco use

When was the last time you used tobacco in any form (including cigarettes, cigars, cigarillos, marijuana/cannabis mixed with tobacco, electronic cigarettes, gum, patches, chewing tobacco or snuff, betel nuts, shisha, hookah/water pipe, etc.)?

- ☐ Never
- ☐ In the past year, specify →
  - ☐ Cigarettes
  - ☐ Cigarillos
  - ☐ Electronic cigarettes
  - ☐ Gum or nicotine patches
  - ☐ Cigars, specify how many cigars you have smoked **in the past 12 months**:___________
  - ☐ Marijuana/cannabis mixed with tobacco
  - ☐ Other tobacco or nicotine products (chewing tobacco or snuff, betel nuts, shisha, hookah/water pipe, etc.)
- ☐ Between 1 and 3 years ago
- ☐ Between 3 and 5 years ago
- ☐ More than 5 years ago

SMOKER RATE

2) Legal status

Were you born in Canada? ☐ YES ☐ NO → a. What is your country of birth?:________________________

→ b. Have you lived in Canada for **at least three years?**

☐ YES ☐ NO → a. Have you lived in Canada for **at least one year**? ☐ YES ☐ NO

→ b. What is your legal status? ☐ Permanent resident ☐ Canadian citizen ☐ Work permit (other than seasonal worker) ☐ Offi... ☐ Othe... ____________

In order to reduce delays in processi... you may provide ... number (SIN) in sectio...

3) Education... tion, incor... et worth

A. Highest l... ducation ... d: ☐ ... a ☐ ... ol or equivalent ☐ A... ship Pro... ☐ C... ☐ Un... te Certificate ☐ Ba... egree ☐ ... uate Degree

B. Occupation

Employment:________________________

Employer (nam... ess): ________________________

Sector of occupation:

- ☐ Military
- ☐ Construction
- ☐ Marine transportation (outside Canada)
- ☐ Natural resources (forestry, mining, oil or gas industry)
- ☐ Arts and entertainment (music, cinema, circus, etc.)
- ☐ Professional sport (athlete)
- ☐ Unemployed
- ☐ Disabled
- ☐ None of the above

C. Income and net worth

Annual income before taxes: $ ______________________ → Annual income before taxes includes the following: Employment income, pensions, annuities, income from financial investments.

Canadian Net Worth (assets – liabilities): $ ______________________ → Assets: What you own Liabilities: What you owe

Foreign Net Worth in canadian dollars (CAD):

Foreign Assets details	Value	Minus Liabilities	Net Value
Investment Holdings	CAD ________	CAD ________	CAD ________
Bank Holdings	CAD ________	CAD ________	CAD ________
Canadian Tax Return (T1 plus T1135)	CAD ________	CAD ________	CAD ________

4) Insurance need

- ☐ Personal
- ☐ Business → What is your level in the company?
  - ☐ I am the sole owner
  - ☐ My spouse and I are the sole owners
  - ☐ I am one of the owners → Purpose of the insurance:
    - ☐ Creditor protection (loans)
    - ☐ Buy-and-sell agreement (inactive shareholder)
    - ☐ Buy-and-sell agreement (active shareholder)
    - ☐ Inheritance, estate protection
    - ☐ Protection of a key person
    - ☐ Other: ______________________
  - ☐ I am an employee

VOID

B **Eligibility questionnaire for disability protection**

1) For the Disability Credit Rider and the Supplementary Income Rider

A- Do you work 21 hours or more per week? ☐ YES ☐ NO ➞ Disability riders not offered

B- Do you work 8 months or more per year? ☐ YES ☐ NO ➞ Disability riders not offered

C- Does your job include manual labour and/or physical work? ☐ YES* ☐ NO *If yes, percentage (%) of manual labour and/or physical work: _______ %

D- Are you self-employed? ☐ YES* ☐ NO *If yes, percentage (%) of time you work at home on a weekly basis: ______ %

2) For Supplementary Income Rider only

Employment income or net business and professional income	• According to your income tax return; • Pre-tax income (less business overhead expenses, if applicable); • Includes bonuses if they are paid on a regular basis. Excludes interest income, rent, capital gains, retirement income and any other income that would be paid whether the insured is disabled or not.

Monthly employment income or income net of business and professional income				Monthly amount of group and/or individual disability insurance already in force		Eligible benefit
$ /month	X 70% =	$ /month	–	$ /month	=	$ /month

⚠ **Proof of income will be required in the event of a claim. We recommend that you attach proof of income (income tax return) with the application.**

12 REQUIREMENTS

Requirements to order

⚠ **If this section is not completed and requirements need to be ordered, iA Financial Group will make the order based on the requirements grid.**

➞ *Use this s... the declarations of ins... are not required.*

1. Indicate the ...nt: ☐ Phone inte... ☐ Vital sign... ...edical examir...

2. Service provide... ______ Authoriza...er: ______

3. Who will order th...ments liste...?

☐ Advisor/Associ... ☐ MGA/... ☐ iA Finan...p (Please provide the follow...nation.)

In which language w... like... the service pro... ☐ English ☐ French ...her: ______

What is the client's co... arrange an appointm...

When is the best time to ... client? ☐ Weekday ☐ ... ☐ Aftern... ☐ Evening

4. Who would you prefer to be your service provider for these requirements? ______

5. If the amount of insurance is over $5,000,000, have you arranged for the inspection report? ☐ YES ☐ NO

If YES, name of the service provider: ______

Sharing of ordered requirements

➞ *Use this section if the declarations of insurability **are not** required. The requirements can be obtained from another company if acquired within the past 12 months (within the past 6 months for insureds aged 70 or older).*

6. Are the requirements for an insurance application **with the same agent** to be obtained from another insurance company? ☐ YES ☐ NO

If YES, name of the company: ______ Reference number: ______

Please also complete the sections 14 F and 14 G and the related questionnaires when required.

Prior declarations

7. Has an individual insurance application been submitted to iA Financial Group for this client in the last 12 months (in the last 6 months for insureds aged 70 or older)? ☐ YES ☐ NO

➞ If YES, has there been changes in your situation since your last declarations?

☐ YES ➞ Please complete declarations of insurability. ☐ NO

VOID

13 PREDECLARATIONS (In order to reduce delays in processing the application, please complete this section.)

Have you sought medical attention or received treatment for or been told you have symptoms of any of the following diseases or disorders?

- ☐ Cerebral vascular accident/stroke (CVA)/Transient ischemic attack (TIA)
- ☐ Angina/Heart attack (with or without bypass surgery/angioplasty)
- ☐ Cancer/Malignant tumor (any site)
- ☐ Major depression (in the last five years) or Bipolar disorder (any duration)
- ☐ Diabetes
- ☐ Hepatitis B or C (other than carrier)
- ☐ Crohn's disease/Ulcerative colitis diagnosed in the last 8 years
- ☐ Chronic obstructive pulmonary disease (COPD)/Emphysema
- ☐ Rheumatoid arthritis polyarthritis/Spondylarthritis
- ☐ No

Please provide details for each disease or disorder indicated.

Disease or disorder	Date of diagnosis	Have you been hospitalized or did you undergo a surgery?	If yes, specify the date
	Y Y Y Y M M	☐ YES ☐ NO	Y Y Y Y M M
	Y Y Y Y M M	☐ YES ☐ NO	Y Y Y Y M M

If you have indicated "Major depression or Bipolar disorder", were you on disability?

☐ YES ☐ NO If YES, specify the dates: From Y Y Y Y M M to Y Y Y Y M M

Full name and address of the doctor(s) following you for the disease(s) or disorder(s) you disclosed:

____

____

____

VOID

Identification no.

VOID

14 DECLARATIONS OF INSURABILITY

NOTE: Do not complete declarations of insurability if requirements have been or will be ordered for this insured.

*For **Transition 4 Illnesses**, please answer **ONLY** the questions indicated with the ✚.*
*For any other coverage, stand alone or combined with **Transition 4 Illnesses**, please answer **ALL** questions of the “Declarations of insurability” section.*

A contract in good faith

iA Financial Group wishes to be a leading business partner for you. We are committed to providing coverage with the best possible conditions in order to offer financial security to you and your loved ones. Therefore, by answering the questions contained in this application, you hereby agree to provide complete and honest information.

However, you are not required to disclose the medical conditions listed below:

- Acne
- Adenoid removal
- Allergies
- Contraceptives
- Cosmetic surgery without complications
- Hemorrhoids
- Menopause
- Otitis
- Pregnancy, delivery or miscarriage without complications
- Tonsil removal
- Vision impairment corrected with glasses or contact lenses

A Family history

✚

Has any member of your family (father, mother, brother, sister) suffered from one of the following conditions **before the age of 65**? ☐ YES ☐ NO

If yes, please indicate the condition and complete the table below. You are not required to disclose a family history of hypertension, high cholesterol or depression.

☐ Cancer*
☐ Multiple sclerosis
☐ A...ic lateral sclerosis (A... Gehrig’s disease)
☐ Po... ...ney disease**
☐ Dea... unknown cause
☐ Cardiovascular or cerebrovascular disease (e.g.: stroke, CVD, TIA)
☐ Parkinson’s disease
☐ ...**
☐ Hemophilia**
☐ Diabetes
☐ Alzheimer’s disease
☐ ...**
☐ ...r** (specify): ______________________
☐ ...n’t know since I wa... ...have no contact with...

Relations...	...se specify ... E.g.: type of cancer*, typ... ...etes, et...	...ximate age ...gnosis

* If you have disclos... ...y history of **breast cancer** or **colo...** ... **question 1 in sectio...**

** Please answer **question 2 in section 15 A.**

B Specialists and medication

✚

1) **In the last five (5) years**, have you consulted a specialist? (Please refer to the list below.) ☐ YES ☐ NO

We consider the following doctors as specialists:

- Cardiologist
- Dermatologist
- Endocrinologist
- Gastroenterologist
- Geriatrician
- Gynecologist
- Hematologist
- Internist (Internal medicine)
- Neonatologist
- Nephrologist
- Neurologist
- Oncologist
- Ophthalmologist
- Otorhinolaryngologist (ENT)
- Pneumologist
- Psychiatrist
- Radiologist
- Rheumatologist
- Surgeon (all specialties)
- Urologist

1. Physician’s specialty (E.g.: Cardiologist)	2. Was this consultation for a follow-up of a pre-existing condition?	3. Was a diagnosis made?	4. Did you undergo exams or tests in connection with this consultation?
	☐ YES, name of the condition*: ______________ ☐ NO (Go to question 3.)	☐ YES, my diagnosis* is: ______________ ☐ NO, everything was normal (Go to question 4.)	☐ YES (If yes, please answer the questions in section **15 N**.) ☐ NO
	☐ YES, name of the condition*: ______________ ☐ NO (Go to question 3.)	☐ YES, my diagnosis* is: ______________ ☐ NO, everything was normal (Go to question 4.)	☐ YES (If yes, please answer the questions in section **15 N**.) ☐ NO
	☐ YES, name of the condition*: ______________ ☐ NO (Go to question 3.)	☐ YES, my diagnosis* is: ______________ ☐ NO, everything was normal (Go to question 4.)	☐ YES (If yes, please answer the questions in section **15 N**.) ☐ NO

* **Please also provide answers to the questions in section 15 related to these conditions (e.g.: asthma) or the questions in section 15 O (Medical general questionnaire), if applicable.** If needed, refer to the medical conditions and questionnaires table attached to this application.

VOID

2) **In the last two (2) years,** were you prescribed or did you refill a prescription that you will need to take for **more than thirty (30) consecutive days**? ☐ YES ☐ NO

If yes, please list each related MEDICAL CONDITION and provide answers to the corresponding questionnaires in section 15 (e.g.: section 15 G for asthma, 15 E for HBP, etc.; or section 15 O - Medical general questionnaire). If needed, refer to the medical conditions and questionnaires table attached to this application.

____

____

C Neurological and mental health

1) **In the last five (5) years,** have you consulted or been treated for any mental illness (e.g.: depression, anxiety, personality disorder, suicide attempt, stress, insomnia)? ☐ YES ☐ NO

If yes, please list these conditions and answer the questions in section 15 D.

____

____

2) Do you suffer from or have you ever been diagnosed with a disorder or disease of the nervous system or a neurological condition? (Please refer to the list below.) ☐ YES ☐ NO

If yes, please select all applicable conditions and answer the questions in section 15 O.

- ☐ Alzheimer's disease
- ☐ Amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease)
- ☐ Autism spectrum disorder
- ☐ Cerebral palsy
- ☐ Cognitive or mental impairment
- ☐ Developmental disorder
- ☐ Down syndrome (trisomy 21 syndrome)
- ☐ Multiple sclerosis
- ☐ Parkinson's disease
- ☐ Other (specify): ____________________

D General medical conditions

1) **In the past five (5) years,** have you consulted or been treated for muscle and bones disorders (e.g.: arthritis, tendinitis, fracture, back pain)? ☐ YES ☐ NO

If ye[illegible] list all disorders an[illegible] the questions as i[illegible]

VOID

1. M[illegible]eletal disorder	[illegible] in the pas[illegible] wo (2) years or [illegible]rrently pre[illegible]	3. [illegible] for at least 12 m[illegible]
	☐ YES ⟶ Questions [illegible] **15 B** or ☐ NO (Go to question 3.)	☐ ☐ [illegible] Questions in section [illegible]**5 C**
	☐ YES ⟶ Questions i[illegible] **15 B** or ☐ NO (Go to question 3[illegible]	☐ ☐ [illegible] Questions in sectio[illegible] **15 C**
	[illegible]ES ⟶ Quest[illegible]on **15 B** or	☐ ☐ [illegible]**5 B** or **15 C**

2) Do you suffer from or have you ever been diagnosed with one of the following diseases or disorders? ☐ YES ☐ NO

If yes, please select all applicable conditions and answer the questions in the section indicated next to each selected condition.

- ☐ Aneurysm ⟶ **section 15 O**
- ☐ Any heart or blood vessel disorder ⟶ **section 15 O**
- ☐ Any type diabetes or glucose intolerance ⟶ **section 15 I**
- ☐ Asthma and currently a smoker ⟶ **section 15 G**
- ☐ Bariatric surgery ⟶ **section 15 O**
- ☐ Cancer ⟶ **section 15 O**
- ☐ Cerebrovascular accident (stroke) ⟶ **section 15 O**
- ☐ Crohn's disease/ Ulcerative colitis ⟶ **section 15 O**
- ☐ Deafness ⟶ **section 15 O**
- ☐ Familial muscular disease (muscular dystrophy) ⟶ **section 15 O**
- ☐ Hepatitis B or C ⟶ **section 15 O**
- ☐ Hereditary disease ⟶ **section 15 O**
- ☐ Herniated disc ⟶ **section 15 B**
- ☐ HIV/AIDS ⟶ **section 15 O**
- ☐ Malformation(s) and/or congenital diseases ⟶ **section 15 O**
- ☐ Sleep apnea ⟶ **section 15 M**
- ☐ Temporary loss of vision or blindness ⟶ **section 15 O**
- ☐ Transient ischemic attack (TIA) ⟶ **section 15 O**
- ☐ Tumor, cyst, nodule, mass, fibroma or polyp ⟶ **section 15 O**

E Investigation and build

1) Are you currently under medical investigation, awaiting results, disabled or do you have any signs or symptoms for which you have not yet consulted a doctor or were advised to undergo a diagnostic test that has not yet been performed? ☐ YES ☐ NO

If yes, please provide as much detail as possible. (For example: nature of symptoms, reason for disability, name of recommended tests)

____

____

Name and address of the physician following you for the disease(s) or disorder(s) you disclosed:

____

Date of your last consultation: Y Y Y Y M M

2) **For this question, you do not have to declare any test that is performed as part of a governmental screening program.**

In the last three (3) years, have you undergone any diagnostic test including: ultrasound, resting or stress electrocardiogram (ECG), CT scan, magnetic resonance imaging (MRI), biopsy, mammogram, colonoscopy, colposcopy, etc.? ☐ YES ☐ NO

If yes, please list all exams and answer the questions in section 15 N*:

____

____

____

*If needed, refer to the medical conditions and questionnaires table attached to this application.

3) Height and weight

a. Height: ____________ ☐ ft ☐ cm

Weight: ____________ ☐ lb ☐ kg

b. In the last year, have you lost more than 10 lb/5 kg (excluding weight loss following childbirth)?

☐ YES → How much weight have you lost? ____________ ☐ lb ☐ kg

☐ NO

F Travels, COVID-19 and sports

1) **Foreign travels**

In the next two (2) years, do you plan to travel or reside outside of Canada or the United States?
Answer YES only if the total duration of your travel equals or exceeds 9 weeks. ☐ YES ☐ NO

If yes, please answer the questions in section 15 S.

2) **COVI[illegible]**

a. **In th[illegible] weeks,** have you [illegible] outside of C[illegible] you trans[illegible] an airport? ☐ YES ☐ NO

If yes, [illegible] he places you [illegible] d/or transit[illegible] and date of return:

☐ Asia [illegible] te of retur[illegible]: Y Y [illegible] D D ☐ [illegible] return: Y Y M M [illegible]

☐ Africa [illegible] of ret[illegible]: Y Y Y [illegible] D D ☐ [illegible] merica [illegible] return: Y Y M M D

☐ Europe [illegible]: Y Y Y [illegible] D D ☐ [illegible] America [illegible] return: Y Y M M D

b. Are you experie[illegible] ns of fever, cough, or [illegible]? ☐ YES ☐ NO

c. **In the last 4 we[illegible]** you or someone close to you be[illegible] irmed or suspecte[illegible] COVID-19[illegible] ☐ YES ☐ NO

d. **In the last 12 months,** have you been hospitalized for the COVID-19 coronavirus disease? ☐ YES ☐ NO

If yes: → Provide the date of hospitalization: Y Y Y Y M M D D

→ Indicate the full name and address of the physician or health care facility that can provide the complete information.

Name of the physician or health care facility: ______________________________

Complete address: ______________________________

____

3) **Sports and aviation**

In the past year, have you practiced aviation (other than as a passenger), scuba diving, parachuting, heli-skiing, a winter sport in areas at risk for avalanches, hang gliding, paragliding, mountaineering, climbing, combat sport, car or motorcycle racing, or do you plan to do so in the next year? ☐ YES ☐ NO

If yes, please select the sports practiced and **answer the questions in section 15 S**.

☐ Automobile or motorcycle racing

☐ Aviation (including hang gliding and paragliding)

☐ Combat sport

☐ Heli-skiing or winter sports in areas at risk for avalanches

☐ Mountaineering or **outdoor** climbing

☐ Parachuting **other than with a tandem instructor**

☐ Scuba diving with **exploration of wrecks, ice diving, cave diving, rescue diving or diving to a depth of more than 75 ft. (23 m)**

☐ I do not practice any of these sports as described. (You do not have to go to section 15 S.)

VOID

G **Life habits**

1) **Within the last five (5) years,** has your driver's licence been suspended or revoked **(excluding due to unpaid fines)?** ☐ YES ☐ NO
If yes, please answer the questions in section 15 R.

2) **Within the last three (3) years,** have you had four (4) or more driving violations **(excluding parking tickets)?** ☐ YES ☐ NO
If yes, please answer the questions in section 15 R.

3) **In the last ten (10) years**, have you been incarcerated, charged or convicted for any criminal offence? ☐ YES ☐ NO
If yes, please answer the questions in section 15 S.

4) On average, do you consume more than twelve (12) alcoholic beverages per week?
(One consumption = 1 bottle of beer or 1 glass of wine or 1 ounce of liquor) ☐ YES ☐ NO
If yes, please answer the questions in section 15 P.

5) **On average, in the past year,** have you used marijuana, cannabis or hashish **more than once in the same week**? ☐ YES ☐ NO
If yes, please answer the questions in section 15 Q.

6) **Within the last ten (10) years**, have you used any drug **other than** marijuana, cannabis or hashish?
(e.g.: anabolic steroids, ecstasy, speed, GHB, magic mushrooms, cocaine, heroin, etc.) ☐ YES ☐ NO
If yes, please answer the questions in section 15 Q.

7) Have you ever been treated for alcohol or drug use, been a member of a support group or been advised to reduce your consumption or to receive treatment for it? ☐ YES ☐ NO

If yes, for what reasons?

☐ Alcohol use ⟶ **Please answer the questions in section 15 P.**

☐ Drug use ⟶ **Please answer the questions in section 15 Q.**

VOID

H **Physicia[illegible] ttending physician'[illegible] ents**

1) Do you [illegible] mily doctor or a [illegible] ealth care f[illegible] ☐ YES ☐ NO
If yes, pl[illegible] cate the name [illegible] address:

____

____

What was the d[illegible] u[illegible] nsultation? Y [illegible] Y M M

2) Does your family [illegible] ar health care facility p[illegible] al informa[illegible] g to the dec[illegible] litions? ☐ YES ☐ NO
If not, please indica[illegible] cian and/or the health care [illegible] nformation for ea[illegible] e conditio[illegible]

Condition or reason	Name of the physician or the health care facility	Address	Date of last consultation
			Y Y Y Y M M
			Y Y Y Y M M
			Y Y Y Y M M
			Y Y Y Y M M

15 ADDITIONAL QUESTIONNAIRES

MEDICAL QUESTIONNAIRES

A Family history

1. Please indicate if, because of your family history of **cancer**, you have ever had tests such as:

- Mammogram: ☐ NO ☐ YES → Date (Y Y Y Y M M) ____ Were the results normal? ☐ NO* ☐ YES
- Colonoscopy: ☐ NO ☐ YES → Date (Y Y Y Y M M) ____ Were the results normal? ☐ NO* ☐ YES

*If no, please provide details of your condition or situation (e.g.: accurate diagnosis, date, treatments, medication, medical follow-up, complications, exams done, time off work, etc.):

____

____

2. Please provide more information regarding the family history for **hereditary** or **neurological** disease (accurate diagnosis, type of manifestation for the person affected, screening tests, results, name and address of physician seen, etc.):

____

____

B **Back disorders** (Examples: Middle back pain, lower back injury, herniated disc, neck pain, etc.)

Declared disorder(s)	I.	II.	III.
Please provide the location of pain or discomfort:			
– Cervical region (neck)	☐	☐	☐
– Th[illegible]ion (middle of the b[illegible]	☐	☐	☐
– Lum[illegible]region (lower ba[illegible]ing sciatic n[illegible]	☐	☐	☐
– Other, [illegible]	____	____	____
Please identi[illegible]st below [illegible] of treatment[illegible] or to come:			
– Injection	☐	☐	☐
– Anti-inflamm[illegible]m[illegible]axant drugs	☐	☐	☐
– Medication de[illegible]hine, opiate or mariju[illegible]bis*	☐	☐	☐
– Medication deri[illegible]thadone*	☐	☐	☐
– Marijuana/cannabis*	☐	☐	☐
– Treatment with health professional (e.g.: physiotherapist, osteopath, etc.)	☐	☐	☐
– Past operation or surgery	☐	☐	☐
– Pending operation or surgery*	☐	☐	☐
– Other treatment* (specify):	____	____	____
– No treatment	☐	☐	☐
When was the last time you experienced problems, had symptoms or had an episode?	Y Y Y Y M M	Y Y Y Y M M	Y Y Y Y M M
*Please provide details of your treatment (type, name of medication, frequency of use, start and end date, etc.):	____	____	____

VOID

Which of the following best describes the severity of your condition?			
– Mild - No limitation or restriction in activities of daily living. Few or no symptoms.	☐	☐	☐
– Moderate - Some limitations or restrictions in activities of daily living. Intermittent symptoms.	☐	☐	☐
– Severe - Several limitations or restrictions in activities of daily living. Persistent or chronic symptoms.	☐	☐	☐
Please specify or clarify your condition (provide as much detail as possible):			
How many days have you been off work (or absent from school) because of this condition in the last twelve (12) months?			
How many distinct episodes have you suffered from with this condition in the past three (3) years?			
Are your back issues caused by a herniated disc?	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
Please provide the frequency of the treatments and symptoms and the duration and dates of your disability and episodes where you have suffered from your condition:			

C **Musculo-articular disorders** (Examples: Dislocated elbow, ankle sprain, arthritis in knee, shoulder bursitis, capsulitis of shoulder, tendinitis, etc.)

Declared disorder(s)	**I.**	**II.**	**III.**
Please [illegible] e location of pain or dis[illegible] ncluding the side of the [illegible] (e.g.: le[illegible] , right elbow, both hi[illegible]			
Please id[illegible] he list below the [illegible] eatment re[illegible] eone:			
– Injecti[illegible]	[illegible]	[illegible]	[illegible]
– Anti-inf[illegible] y or muscl[illegible] t drugs	[illegible]	[illegible]	[illegible]
– Medicatio[illegible] l from n[illegible] , opiate or ma[illegible] annabis*	[illegible]	[illegible]	[illegible]
– Medication [illegible] from [illegible] one*	[illegible]	[illegible]	[illegible]
– Marijuana/ca[illegible]	[illegible]	[illegible]	☐
– Treatment wit[illegible] sional (e.g.: physiothe[illegible] path, etc.)	☐	[illegible]	☐
– Past operation or surgery	☐	☐	☐
– Pending operation or surgery	☐	☐	☐
– Other treatment* (specify):			
– No treatment	☐	☐	☐
When was the last time you experienced problems, had symptoms or had an episode?	Y Y Y Y M M	Y Y Y Y M M	Y Y Y Y M M
*Please provide details of your treatment (type, name of medication, frequency of use, start and end date, etc.):			
How many days have you been off work (or absent from school) because of this condition in the last twelve (12) months?			
How many distinct episodes have you suffered from with this condition in the past three (3) years?			
Has this condition required the installation of a prosthesis, orthesis or any other artificial hardware? If yes, please provide more information regarding your treatment (type of treatments, follow-ups, complications, etc.):	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
Please provide the frequency of the treatments and symptoms and the duration and dates of your disability and episodes where you have suffered from your condition:			

VOID

D **Mental health** (Examples: Mood disorder, generalized anxiety disorder, depression, adjustment disorder, stress, psychosis, bipolar disorder, personality disorder, etc.)

Declared conditions	**I.**	**II.**	**III.**
Please list every symptomatic episode for this condition:			
a) Duration (days, weeks or months)			
Start date	Y Y Y Y M M	Y Y Y Y M M	Y Y Y Y M M
b) Duration (days, weeks or months)			
Start date	Y Y Y Y M M	Y Y Y Y M M	Y Y Y Y M M
Have you been off work or disabled because of this condition? ☐ YES ☐ NO If yes, please specify all disability episodes for this condition:			
a) Duration (days, weeks or months)			
Start date	Y Y Y Y M M	Y Y Y Y M M	Y Y Y Y M M
b) Duration (days, weeks or months)			
Start date	Y Y Y Y M M	Y Y Y Y M M	Y Y Y Y M M
What is the number of different medications that you are currently taking for this condition?			
If you do not take any (zero) medication, have you already taken medication for your condition? If yes, [illegible]e date of your last me[illegible] treatment?	☐ YES ☐ NO Y Y Y Y M M	☐ YES ☐ NO Y Y [illegible]	☐ YES ☐ NO Y Y Y Y M M
Have you [illegible]n hospitalized or [illegible]tient therap[illegible]ondition?	[illegible] ☐ NO	☐ YE[illegible] NO	[illegible] ☐ NO
If yes, pleas[illegible] more infor[illegible]out your ho[illegible]on or therapy (date[illegible]ents, com[illegible]s, follow-ups[illegible]etc.):			

VOID

E **High blood press**[illegible]mpl[illegible] hypertension, h[illegible] pressure, elevated blood [illegible] etc.)

1) Is your conditio[illegible] with no complicatio[illegible]g to your physician?

☐ YES

☐ NO ➞ Pleas[illegible]ore information regarding the c[illegible] (types of complica[illegible]es, exams, [illegible]

____

____

____

2) Are you currently being treated with medication for this condition?

☐ NO ➞ Please specify or clarify your condition (provide as much detail as possible):

____

____

☐ YES ➞ Has your medication been changed in the last six months (addition/replacement of a medication or increase of dosage)? ☐ YES ☐ NO

F **Cholesterol** (Examples: Elevated cholesterol, hyperlipidemia, elevated lipids, elevated triglycerides, etc.)

1) When was your diagnosis made? Y Y Y Y M M

2) Has your physician ever informed you that you suffer from familial hypercholesterolemia (familial dyslipidemia)? ☐ YES ☐ NO

3) Are you currently being treated with medication for this condition?

☐ YES

☐ NO ➞ Have you ever been treated for this condition?

☐ NO

☐ YES ➞ What are the reasons for stopping the medication?

☐ Weight loss
☐ Increase of physical activity
☐ Improved nutrition (diet, etc.)
☐ Present or past pregnancy ________________
☐ Other:

G **Asthma** (Examples: Asthma attack, asthma bronchitis, allergic asthma, etc.)

1) How many times per week do you experience symptoms? ___________ times/week

2) How many times per week do you take medication for your condition? ___________ times/week

3) Have you taken oral steroid tablets (e.g.: Prednisone or Prednisolone) in the last twelve (12) months for this condition? ☐ YES ☐ NO

4) Have you been hospitalized within in the last twelve (12) months for this condition? ☐ YES ☐ NO

5) How many days have you been off work (or absent from school) because of this condition in the last twelve (12) months? ___________

H **Hypothyroidism** (Examples: Underactive thyroid gland, hypoT4, etc.)

Is your condition fully controlled without complications? ☐ YES ☐ NO

If no, please provide more information regarding the complications of your condition (type of complication, dates, exams, treatments, follow-ups, etc.):

____

____

I **Diabetes** (Examples: Type 1 or 2 diabetes, diabetes mellitus, impaired glucose tolerance, gestational diabetes, etc.)

1) Which of the following currently represents your condition?

☐ Type 1 (juvenile or insulin-dependent diabetes)
☐ Type 2 (noninsulin-dependent diabetes)
☐ Gestational diabetes (current)
☐ Gestational diabetes (prior history)
☐ Past history of diabetes (other than pregnancy)
☐ Impaired glucose intolerance or pre-diabetes
☐ Unknown type diabetes

2) When was your diagnosis made? Y Y Y Y M M

3) What is the type of treatment for your diabetes?

☐ I ☐ Oral medication ☐ n ☐ None

If you d "Gestational di prior histor

4) Are you pregnant?

☐ YES ou currently an 24 week t? ☐ YES ☐ NO

☐ NO icensed professional d you fully recovered from dition? ☐ NO

J **Gastroesophage** (Ex yspepsia, hear mach acidity, esophageal lux esop c.)

1) Please identify symptoms:

☐ Mild sympto nce with activities of no medication

☐ Moderate sym interference with activitie on.

☐ Severe symptoms, significant interference with activities of daily living.

VOID

2) If severe symptoms, please provide more information regarding your condition and the symptoms (type of symptoms, complications, treatments, follow-ups, etc.):

____

____

____

3) Are you awaiting tests, exams or surgeries for this condition? ☐ YES ☐ NO

4) If yes, please provide more information regarding upcoming exams or surgeries (types of exams or surgery, date, follow-ups, etc.):

____

____

____

5) Was the condition confirmed as benign or non-malignant?

☐ YES ☐ NO ⟶ Given that your condition was not benign, please provide more details (diagnosis, treatments, follow-ups, etc.):

____

____

____

K **Attention deficit disorder** (Examples: Attention deficit hyperactivity disorder, ADHD, concentration disorders, hyperactivity, etc.)

→ **If you are less than 18 years old, please answer the following questions:**

1) Which of the following best describes your situation?
   - ☐ Normal school level for age, regular school, no associated problems. → Please go to question 3.
   - ☐ Beneath normal school level, associated problems present. → Please go to question 2.

2) Please provide details concerning your condition (symptoms, time off work or off school, employment or educational path, etc.):

   ____

3) Have you ever been referred to a specialist for this condition? ☐ YES ☐ NO

4) How many follow-ups per year do you have for this condition? ______________________________

5) What is the number of different medications that you are currently taking for this condition? ______________________________

→ **If you are 18 years of age or older, please answer the following questions:**

1) Please identify the severity of your attention deficit disorder with or without hyperactivity (ADD/ADHD):
   - ☐ Mild, little to no interference with daily activities → Please go to question 2.
   - ☐ Moderate interference with daily activities (disorganization, time off work, etc.) → Please go to question 3.
   - ☐ Severe → Please go to question 3.
   - ☐ Recovered, history of attention deficit disorder → When did you last take treatment for this condition? Y Y Y Y M M

2) If you answered “Mild”, what is the number of different medications that you are currently taking for this condition? __________

   If you answered more than one medication, please provide more information regarding your treatment:

   ____

   ____

3) If you a[illegible] “Moderate” or “Se[illegible]ease provide [illegible]ymptoms, tim[illegible] or off sch[illegible] etc.):

   ____

   ____

L **Migraine and [illegible]e** (Exam[illegible]sion headac[illegible]aine, etc.)

1) Which of the [illegible] best [illegible]s your headac[illegible]
   - ☐ (a) Increasi[illegible]u[illegible]d/or recent onset and still u[illegible]on
   - ☐ (b) Mild/occas[illegible] use of over the counter medication [illegible]cation
   - ☐ (c) Mode[illegible] the use o[illegible] counter medication and/o[illegible]nal use of [illegible]on medication
   - ☐ (d) Seve[illegible]ent, resist[illegible]

2) If (a) or (d), please provide more information regarding your condition and the symptoms (types of symptoms, complications, treatments, follow-ups, etc.):

   ____

   ____

VOID

M **Sleep apnea** (Examples: Obstructive sleep apnea, apnea-hypopnea syndrome, etc.)

1) Which of the following best describes the degree of severity of your symptoms at the time of diagnosis?

   ☐ Mild ☐ Moderate ☐ Severe ☐ Unknown

2) Are you currently being treated with CPAP or BIPAP machines?
   - ☐ YES → Hours of use per night: __________ hours/night. Please provide the starting date of your treatment: Y Y Y Y M M
   - ☐ NO

3) Has the condition been fully investigated?

   ☐ YES ☐ NO → Please provide information regarding your incomplete investigation (exams done, treatments, follow-ups, upcoming investigations, date, etc.):

   ____

   ____

4) Have you been diagnosed with central sleep apnea? ☐ YES ☐ NO

5) Has your sleep apnea affected your normal daily activities?

   ☐ NO ☐ YES → Please specify or clarify your condition (provide as much detail as possible):

   ____

   ____

6) Have you had any motor vehicle accidents in the past three (3) years? ☐ YES ☐ NO

N Diagnostic tests or exams

1) Name of the exam: ____________________

a. Were the results confirmed to you as normal?

☐ YES ☐ NO → Please provide more information regarding your results (accurate diagnosis, treatment, date of diagnosis, follow-up, etc.):

____

____

b. Please provide the date of the exam: Y Y Y Y M M

c. Please provide more details about the test or exam (reason for exam, treatments, medication, medical follow-up, complications, other exams done, time off work, etc.):

____

____

---

2) Name of the exam: ____________________

a. Were the results confirmed to you as normal?

☐ YES ☐ NO → Please provide more information regarding your results (accurate diagnosis, treatment, date of diagnosis, follow-up, etc.):

____

____

b. Please provide the date of the exam: Y Y Y Y M M

c. Please provide more details about the test or exam (reason for exam, treatments, medication, medical follow-up, complications, other exams done, time off work, etc.):

____

____

---

3) Name of the exam: ____________________

a. Were the results confirmed to you as normal?

☐ YES ☐ NO → Please provide more information regarding your results (accurate diagnosis, treatment, date of diagnosis, follow-up, etc.):

____

____

b. Please provide the date of the exam: Y Y Y Y M M

c. Please provide more details about the test or exam (reason for exam, treatments, medication, medical follow-up, complications, other exams done, time off work, etc.):

____

____

VOID

O Medical general questionnaire

1) Please provide the exact diagnosis of your condition: ____________________

2) When was your diagnosis made? Y Y Y Y M M

3) Have you had any treatments (including medication) for your condition?

☐ NO ☐ YES → Please provide more information regarding the treatment(s) received (surgery, medication, dosage, duration, frequency, follow-up, etc.):

____

____

4) Have you had any exams or tests for your condition?

☐ NO ☐ YES → Please provide more information regarding the exams or the tests performed (type of exams, results, dates, follow-up, etc.):

____

____

5) Have you been off work or disabled because of this condition?

☐ NO ☐ YES ➞ Please indicate the beginning and end dates of your disability period:

Start: Y Y Y Y M M End: Y Y Y Y M M

Start: Y Y Y Y M M End: Y Y Y Y M M

Start: Y Y Y Y M M End: Y Y Y Y M M

6) Have you been hospitalized because of this condition?

☐ NO ☐ YES ➞ Please provide the dates and duration of your hospitalizations:

Date: Y Y Y Y M M Duration: ___________________

Date: Y Y Y Y M M Duration: ___________________

Date: Y Y Y Y M M Duration: ___________________

7) Are you fully recovered from this condition?

☐ YES ➞ Please indicate since what date you have been fully recovered: Y Y Y Y M M

☐ NO ➞ Please provide more details about your condition:____

8) Please provide any other relevant details about your condition:

____

____

____

- -

VOID

1) Please pro exact diagn our conditio ____

2) When was yo osis m Y Y M

3) Have you had a me ding medication, condition?

☐ NO ☐ Y ovide more informa ding the treatment(s) (surgery, n , dosage, frequency, follow-

____

____

4) Have you had any exams or tests for your condition?

☐ NO ☐ YES ➞ Please provide more information regarding the exams or the tests performed (type of exams, results, dates, follow-up, etc.):

____

____

5) Have you been off work or disabled because of this condition?

☐ NO ☐ YES ➞ Please indicate the beginning and end dates of your disability period:

Start: Y Y Y Y M M End: Y Y Y Y M M

Start: Y Y Y Y M M End: Y Y Y Y M M

Start: Y Y Y Y M M End: Y Y Y Y M M

6) Have you been hospitalized because of this condition?

☐ NO ☐ YES ➞ Please provide the dates and duration of your hospitalizations:

Date: Y Y Y Y M M Duration: ___________________

Date: Y Y Y Y M M Duration: ___________________

Date: Y Y Y Y M M Duration: ___________________

7) Are you fully recovered from this condition?

☐ YES ⟶ Please indicate since what date you have been fully recovered: Y Y Y Y M M [| | | | |]

☐ NO ⟶ Please provide more details about your condition:______________________________

8) Please provide any other relevant details about your condition:

____

____

____

NON-MEDICAL QUESTIONNAIRES

P Alcohol

To be completed if you answered YES to question 14.G.4 or 14.G.7 (alcohol use).

1) Please indicate your typical alcohol consumption **per week** (1 consumption = 1 bottle of beer or 1 glass of wine or 1 ounce of liquor):______________ consumptions/week

2) Have you ever reduced your alcohol consumption?

☐ NO

☐ YES ⟶ Please answer the following questions:

a) When did you begin reducing? Y Y Y Y M M [| | | | |]

b) Please indicate your past alcohol consumption **per week** (1 consumption = 1 bottle of beer or 1 glass of wine or 1 ounce of liquor): ______________ consumptions/week

Q Drugs

Cannabi[illegible]ana, hashish, etc.) [illegible]e completed i[illegible]uestion 14.G.5, 1[illegible]4.G.7 (dr[illegible]

Have y[illegible]sed cannabis (ma[illegible]ashish, etc.)

☐ NO

☐ YES [illegible]u currently [illegible]abis (mariju[illegible]ish, etc.) or did you do s[illegible]st year?

⟶ [illegible]as the last ti[illegible]ed it? Y Y Y Y [| | |]

[illegible] provide the av[illegible]ntity and frequency of yo[illegible]s (marij[illegible]ish, etc.) [illegible]e quitting:

[illegible]sumption: ________ [illegible]er ________ ([illegible]month)

☐ [illegible]ase provide the average [illegible]rent cannabi[illegible]a, hashis[illegible]

Consumption: ________ p[illegible] [illegible]y/week/month)

Have you ever reduced your consumption? ☐ NO

☐ YES ⟶ Please provide the average quantity and frequency of your marijuana/cannabis use before reducing:

Consumption: ________ per ________ (day/week/month)

When did you reduce your consumption? Y Y Y Y M M [| | | | |]

VOID

Other drugs

Have you ever used other drugs?

☐ NO ☐ YES ⟶ Please disclose every drug usage, excluding cannabis (marijuana, hashish, etc.):

Drug type	Last time of use	Number of uses and frequency
	Y Y Y Y M M	________ per ________ (day/week/month)
	Y Y Y Y M M	________ per ________ (day/week/month)
	Y Y Y Y M M	________ per ________ (day/week/month)

R Driving record

If you answered Yes to question 14.G.1 (driver's licence suspended), please answer the questions in sections 1 and 2 below.

If you answered Yes to question 14.G.2 (4 or more driving violations in the last 3 years), please complete only the table in section 1.

SECTION 1

Type of moving violation	Date of violation
	Y Y Y Y M M
	Y Y Y Y M M
	Y Y Y Y M M
	Y Y Y Y M M
	Y Y Y Y M M

SECTION 2

1) Please indicate the type of driving licence you have:

☐ Learner's licence ☐ Novice's licence / Probationary licence ☐ Regular driver's licence ☐ Other

If "Other", please provide details about your driving licence: ____________________

2) Has your licence been reinstated?

☐ N ES ⟶ Please provi te when your li Y Y Y Y M

3) Did you e your licence wa ed (excludin a restricted lice vehicle equi an alcohol terlock device)? ☐ YES ☐ NO

S Non-medica questionna

If you answ to the qu n "foreign tra F.1), "sports and aviation" "crimi (14.G.3), vide all relevant infor as listed belo

- **For foreign** Cour will visit, date ure, duration, reasons for
- **For sports a** ing and end date, type and characteristi precise a , acciden es experienced, fre c.
- **For criminal re** the criminal act, date nviction, proba d end date

Please provide det

____

____

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Identification no.

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16 SIGNATURES AND AUTHORIZATION

We, the proposed insured and the applicant, declare that all answers and explanations given in this application, or if applicable, in any other questionnaire or form in connection herewith, as well as during any interview, by telephone or otherwise, relating to the declarations of insurability, are true and complete.

We agree that the insurance takes effect as of the acceptance by Industrial Alliance Insurance and Financial Services Inc. ("iA Financial Group") of the application inasmuch as the latter has been accepted without modification, the first premium has been paid and no change has taken place in the insurability of the proposed insureds since the signing of the application. We acknowledge that our declaration of insurability may be completed during an interview, by telephone or otherwise, which interview may be recorded, and that iA Financial Group will rely upon, among other things, the said declaration in determining whether to accept the application.

We authorize iA Financial Group and its reinsurers, to exchange with its subsidiaries, its underwriting service providers and other insurers, reinsurers or financial institutions, the personal information obtained for the purposes of studying this request and to inquire of them for the appraisal of the risk or in the event of a claim, or to exchange with an organization offering medical assistance, personal information for relevant purposes under the insurance coverage in the event of a critical illness.

In the event that iA Financial Group refuses to issue the disability credit rider, iA Financial Group may evaluate the possibility of offering us another disability insurance.

In the event of the death or disability of the applicant or proposed insured, the beneficiary, the heir or the liquidator of the estate is expressly authorized to supply iA Financial Group, when required by the latter, with all information and authorizations necessary to study the death benefit or disa[illegible]m and obtain the requir[illegible]entation.

We hereby authorize any person or any other public, quasi-public or private institution holding our personal information, particularly: any health care professional, health or social service establishment, the Régie de l'assurance maladie du Québec, any insurance or reinsurance company, MIB LLC, financial institutions, personal information agents, professional investigation agencies or any credit reporting agency, financial consultants, our employer or ex-employer and any other body holding personal, medical or health-related information concerning ourselves to supply this information to iA Financial Group, and its reinsurers for the risk assessment, for case management or for any investigation required for the study of any claim. We also authorize iA Financial Group to exchange personal information with these people and entities, as well as with its reinsurers, as required.

In addition, iA Financial Group, its affiliates and their agents can access information about us to know us better, better meet our needs and offer the best possible service and client experience. (If you do not wish to allow this access, please send a written request to: iA Financial Group, Policyowner Services, 1080 Grande Allée West, PO Box 1907, Station Terminus, Quebec City, QC G1K 7M3.)

We authorize iA Financial Group and its reinsurers to make a brief report to the MIB LLC.

We also authorize iA Financial Group to release any abnormal test results to our personal physician.

ELECTRONIC TRANSMISSION OF DOCUMENTS

We acknowledge that documents and communications regarding all of our contracts with iA Financial Group, including the contract itself, will be sent to us in electronic format and we can consult them in My Client Space (available on ia.ca). We understand that any document will be considered deli[illegible] soon as it [illegible] My Client Space and that documents that are currently only [illegible]n paper f[illegible]ia regular mail. A copy of [illegible] document cou[illegible] be sent to[illegible]

We agree that a p[illegible] of this aut[illegible]n is as val[illegible] original.

Signed at	Province	[illegible]is	
			20

Proposed insured (if ag[illegible]ner)	**[illegible]uardian or parent (if ins[illegible] authoriz[illegible]**	**Witne[illegible]licable)**
Last and first name (write[illegible]	[illegible]first name (write le[illegible]	Last a[illegible]ame (write legibly)
Signature	Signature	Signature
X	X	X

⚠ **The signature of one of the two parents is required for a minor proposed insured if anyone other than the parents is the applicant.**

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17 AUTHORIZATIONS

We hereby authorize any health care professional as well as any other public or private health or social service establishment, any insurance company, MIB LLC, financial institutions, personal information agents or professional investigation agencies and any public body holding information concerning ourselves or our family, particularly medical information, and any other public or private body holding medical or health-related information concerning ourselves or our family, to supply this information to Industrial Alliance Insurance and Financial Services Inc. and its reinsurers for the risk assessment or the investigation necessary for the study of any claim.

A photocopy of this authorization shall be as valid as the original.

Signed at ____________ this ____________ day of ____________ 20____

Proposed insured (Quebec, age 14 and over; outside Quebec, age 16 and over) X ____________

Witness X ____________

Legal guardian or parent (if insured is not authorized to sign) X ____________

We hereby authorize any health care professional as well as any other public or private health or social service establishment, any insurance company, MIB LLC, financial institutions, personal information agents or professional investigation agencies and any public body holding information concerning ourselves or our family, particularly medical information, and any other public or private body holding medical or health-related information concerning ourselves or our family, to supply this information to Industrial Alliance Insurance and Financial Services Inc. and its reinsurers for the risk assessment or the investigation necessary for the study of any claim.

A photocopy of this authorization shall be as valid as the original.

Signed at ____________ this ____________ day of ____________ 20____

Proposed insured (Quebec, age 14 and over; outside Quebec, age 16 and over) X ____________

Witness X ____________

Legal guardian or parent (if insured is not authorized to sign) X ____________

VOID

Th... ent forms below ... be complete... oposed insur... t reside... rta only.

iA Financial Group ...a

...RED 1

Conse... sclosure ... vidually Identi... th Information
...uthorize... ction 34 of the *H... ormation Act*)

Please print in ink.

I, ____________ , a... e attached) individually identifyin...

☐ diagnostic, treatment a... ormation ... gistration informa... health services provider informat...

concerning myself to be disc... ____________ (nam... an), in acc... n section 34 ... *Information Act*, to Indust... nsurance and Financial Services Inc., fo... in... s):

I understand why I have been aske... y individually identifying informatio... efits of consenting o... consent to ... ying information.
I understand that I may revoke this ... y time.

Dated this ______ (day) of ______ (month), ______ (year) Expiry date (if any) ______ (day) of ______ (month), ______ (year)

Client or authorized representative's signature X ____________

Source of representative's authority (If applicable. Ex.: executor, guardian, etc.) (Refer to section 104(1) of the Act.) ____________

Client or authorized representative's name ____________

Witness' signature X ____________

Witness' name ____________

HEAD OFFICE: Industrial Alliance Insurance and Financial Services Inc., 1080 Grande Allée West, PO Box 1907, Station Terminus, Quebec City, Quebec G1K 7M3

iA Financial Group ia.ca

INSURED 2

Consent to Disclosure of Individually Identifying Health Information
(Authorized by Section 34 of the *Health Information Act*)

Please print in ink.

I, ____________ , authorize (the attached) individually identifying

☐ diagnostic, treatment and care information ☐ registration information ☐ health services provider information

concerning myself to be disclosed by ____________ (name of custodian), in accordance with section 34 the *Health Information Act*, to Industrial Alliance Insurance and Financial Services Inc., for the following purpose(s):

I understand why I have been asked to disclose my individually identifying information, and am aware of the risks or benefits of consenting or refusing to consent to the disclosure of my individually identifying information.
I understand that I may revoke this consent at any time.

Dated this ______ (day) of ______ (month), ______ (year) Expiry date (if any) ______ (day) of ______ (month), ______ (year)

Client or authorized representative's signature X ____________

Source of representative's authority (If applicable. Ex.: executor, guardian, etc.) (Refer to section 104(1) of the Act.) ____________

Client or authorized representative's name ____________

Witness' signature X ____________

Witness' name ____________

HEAD OFFICE: Industrial Alliance Insurance and Financial Services Inc., 1080 Grande Allée West, PO Box 1907, Station Terminus, Quebec City, Quebec G1K 7M3

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ia.ca

Identification no.

VOID

Give to insured

18 PRE-NOTICE FROM MIB LLC

Information regarding your insurability will be treated as confidential. Industrial Alliance Insurance and Financial Services Inc. (“iA Financial Group”) or its reinsurers may, however, make a brief report thereon to MIB LLC, which operates an information exchange on behalf of insurance companies that are members of MIB Group Inc.. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB by emailing canadadisclosure@mib.com or calling 866-692-6901. If you question the accuracy of information in MIB’s file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB’s information office is: 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734 USA.

iA Financial Group, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

NOTICE

A representative from an inspection company may contact you to obtain information concerning your personal and financial status. A doctor or personnel from a paramedical organization or a clinic may be asked to complete a medical examination and/or collect a blood or urine sample. The analysis will be used to determine the presence or absence of different abnormalities such as cholesterol, diabetes, hepatic disorders or the use of medication, drugs, nicotine, and infection by the AIDS virus.

Before collecting a blood or urine specimen, your written consent will be required.

DISCLOSURE STATEMENT

This application is being submitted by an authorized representative of iA Financial Group who will receive compensation if the application is accepted and in no way imposes on the applicant an obligation to transact additional business with said representative.

CONSTITUTI[illegible] FILE AND PRO[illegible] OF PERS[illegible]

For the purpose [illegible] you insurance [illegible], credit or [illegible]ementary products that may respond [illegible] needs, iA Fi[illegible]Group will [illegible] a file in which your personal informatio[illegible] kept.

This file will remain s[illegible]nfidentia[illegible] be kept in [illegible] of iA Financial Group. Only employees or rep[illegible]ves wh[illegible] this informatio[illegible] of their duties will have access to this file.

You are entitled to acces[illegible]ormation contained [illegible] and, if necessary, to have it rectified by sendi[illegible]quest to the following a[illegible]

[illegible]ial Alliance [illegible] and Fina[illegible]vices Inc.
[illegible]vacy Offi[illegible]
[illegible]nde Allé[illegible]
[illegible]907, Sta[illegible]inus
[illegible]ity, QC

[illegible]ial Grou[illegible] tablish a [illegible] clients for its own [illegible]al prospecting [illegible]s or those [illegible]er compa[illegible] group. However, yo[illegible]led to have your [illegible] removed fr[illegible]st by mak[illegible]ten request to th[illegible] the Chief Privacy [illegible]er at the add[illegible]ated abov[illegible]

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19 APPENDIX – MEDICAL CONDITIONS & NON-MEDICAL CONDITIONS AND ADDITIONAL QUESTIONNAIRES

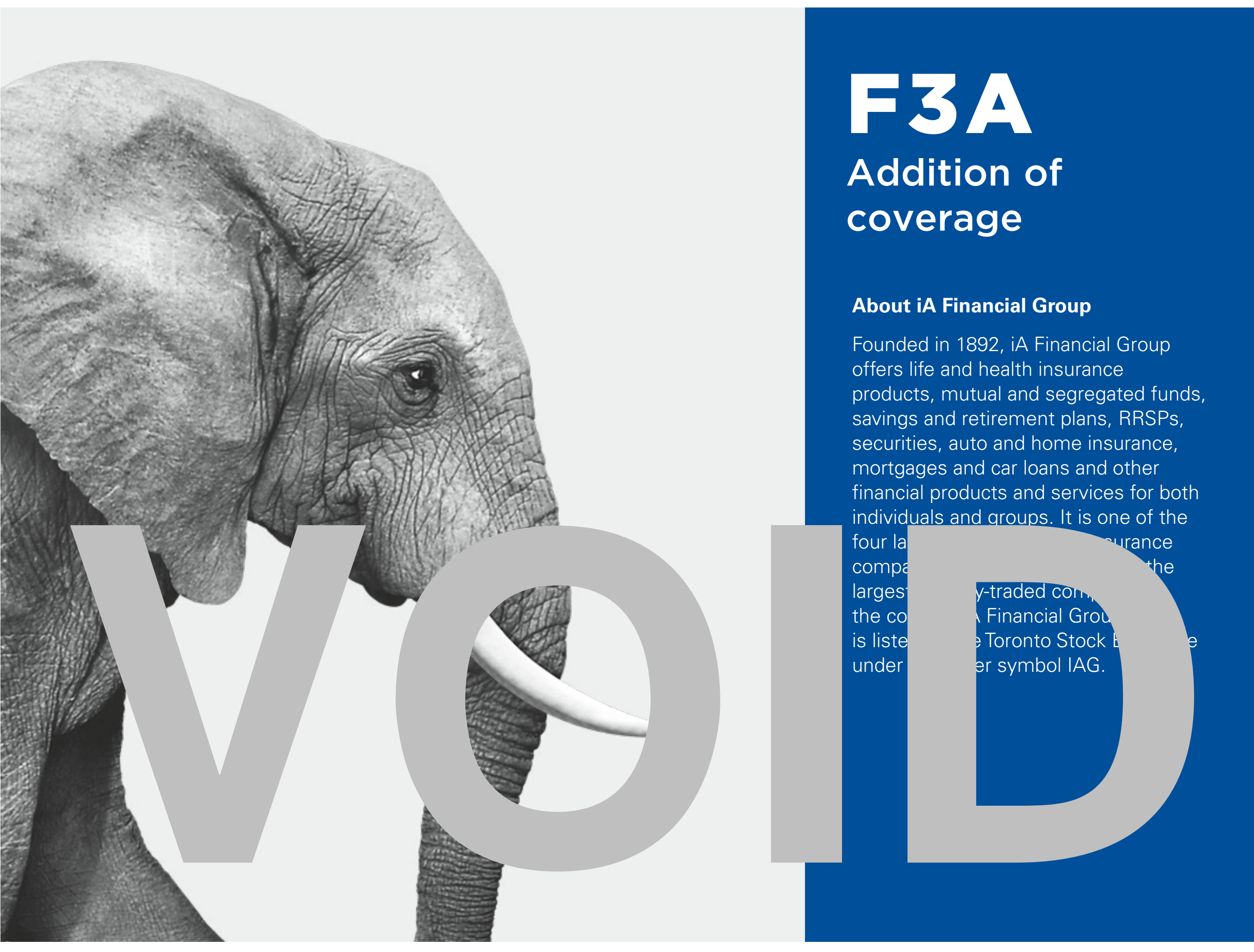
Medical conditions

Examples of Medical conditions disclosed		Medical Questionnaires to complete
• Herniated disc • Lower back injury	• Middle back pain • Neck pain, etc.	**B- Back disorders** NB: Excluding Musculo-articular disorders
• Ankle sprain • Arthritis in knee • Bursitis	• Dislocated elbow • Shoulder capsulitis • Tendinitis, etc.	**C- Musculo-articular disorders** NB: Excluding Back disorders
• Adjustment disorder • Anxiety, stress • Bipolar disorder • Burn out • Depression	• Fatigue • Generalized anxiety disorder • Mood disorder • Personality disorder • Psychosis, etc.	**D- Mental Health**
• Elevated blood pressure • HBP	• High pressure • Hypertension, etc.	**E- High blood pressure**
• Cholesterol elevation • Hyperlipidemia	• Lipids raised • Triglycerides raised, etc.	**F- Cholesterol**
• Allergic asthma • Asthma and currently a smoker	• Asthma attack • Asthma bronchitis, etc.	**G- Asthma** NB: Excluding pulmonary bronchitis, chronic obstructive pulmonary bronchitis (COPB), Emphysema, Chronic obstructive pulmonary disease (COPD)
• HypoT4	• Underactive thyroid gland, etc.	**H- Hypothyroidism** NB: Excluding Hyperthyroidism, Thyroid disorder or Thyroiditis
• Diabetes • Diabetes mellitus • DM	• Gestational diabetes • Glucose intolerance • Type 1 ou 2 diabetes, etc.	**I- Diabetes**
• Dyspepsia [illegible] • Esophageal [illegible] • Heartburn	• [illegible]ux esophagitis • [illegible]mach acidity • [illegible]omach pain, [illegible]	**[illegible]- Gastroesop[illegible] reflux**
• ADHD • Attention defici[illegible] • Attention deficit [illegible]ity disorder	• [illegible]oncentratio[illegible] • Hyperactivit[illegible]	**[illegible]ention [illegible]isorder**
• Headache • Migraine	• Tension h[illegible] etc.	**[illegible]aine a[illegible]dache**
• Apnea/Hypopnea Sy[illegible] • Obstructive sleep apn[illegible]	• Obstructiv[illegible]nea syndrome • Sleep apne[illegible]	**[illegible]ep Apn[illegible]**
• Biopsy • Colonoscopy/coloscopy • Colposcopy • Echography/Ultrasound (U[illegible] abdominal, cardiac, breast, [illegible] • Electrocardiogram (ECG/EKG)	• Magnetic re[illegible]aging (MRI) • Mammograph[illegible] • Scanner (Pet sc[illegible] • Scintigraphy • Stress electrocardiogra[illegible] • X-ray, etc.	**[illegible] Diagnostic [illegible]r exam[illegible]**
• Aneurysm • Angina/Heart attack • Any heart or blood vessel disorder • Bariatric surgery • Cancer/Malignant Tumor • Cerebral vascular accident/stroke (CVA) • Transient ischemic attack (TIA) • Chronic obstructive pulmonary bronchitis (COPB) • Chronic obstructive pulmonary disease (COPD) • Crohn's disease • Deafness • Emphysema	• Familial muscular disease (muscular dystrophy) • Hepatitis B or C • Hereditary disease • HIV/AIDS • Hyperthyroidism • Rheumatoid polyarthritis/Spondylarthritis • Temporary loss of vision or blindness • Thyroid disorder (excluding Hypothyroidism) • Thyroiditis • Tumor, cyst, nodule, mass, fibroma or polyp • Ulcerative colitis, etc.	**O- Medical general questionnaire**

VOID

Non-medical conditions

Examples of Non-medical conditions disclosed		Non-medical Questionnaires to complete
• Alcohol use	• Treatment, support group or advised to reduce your consumption	**P- Alcohol**
• Drug use	• Treatment, support group or advised to reduce your consumption	**Q- Drugs**
• Driver's licence	• Driving violation	**R- Driving record**
• Criminal record • Foreign travel	• Sports and aviation	**S- Non-medical general questionnaire**



F3A(23-05) ACC

Service Centre contact information

Toll-free: 1-844-4 **iA-INFO** (442-4636) Email: **infolife@ia.ca**

Quebec	Toronto	Vancouver
Industrial Alliance Insurance and Financial Services Inc. Head Office	Industrial Alliance Insurance and Financial Services Inc. Toronto Service Centre	Industrial Alliance Insurance and Financial Services Inc. Vancouver Service Centre
Policyowner Services 1080 Grande Allée West PO Box 1907, Station Terminus Quebec City, QC G1K 7M3	Policyowner Services 522 University Avenue Suite 400 Toronto, ON M5G 1Y7	Policyowner Services 988 W. Broadway, Suite 400 PO Box 5900 Vancouver, BC V6B 5H6
Fax: 1-866-572-1075	Fax: 1-877-780-7231	Fax: 1-844-739-0634

INVESTED IN YOU.

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Industrial Alliance Insurance and Financial Services Inc.

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