Acci-Jet Program

F42A
Application

New sale ☐

Change in coverage ☐ Contract number

Name of representative	Email address of representative*	Code	%
Name of representative	Email address of representative*	Code	%
Firm	Email address of firm*	Code	

*If your current email on file has not changed, please leave this field blank.

F42A(22-09) ACC

iA Financial Group

INVESTED IN YOU.

1. GENERAL INFORMATION (Policyholder / Primary Insured)

Last name:	First name:
Email address:	SIN:
Date of birth: Y Y Y Y M M D D ☐ Save age	Gender: ☐ F ☐ M
Country of birth:	Province or State:
If other than Canada, in Canada since: Y Y Y Y M M D D	
Current legal status: ☐ Canadian citizen ☐ Permanent resident ☐ Other, specify:	

Home address:

Address: no.: street:		apt.:
City:	Province:	Postal code:
Home/Cell telephone number:	Office telephone number:	Ext.:

Business address: ☐ Same as home address

Name of company: (Policyholder ☐ Yes ☐ No)	Date of employment: Y Y Y Y M M D D	
Address: no.: street:		apt.:
City:	Province:	Postal code:
Home/Cell telephone number:	Office telephone number:	Ext.:

Language of correspondence: ☐ English ☐ French	Mailing address: ☐ Home ☐ Office

2. OCCUPATION

Occupation:	Brief description of tasks:
Manual tasks: %	Administrative tasks or Supervision: %
Annual Income (see section 3): $	

Do you pay contributions to Employment Insurance (EI)? ☐ Yes ☐ No

Do you work from home more than 50% of the time? ☐ Yes ☐ No

Are you a truck driver? ☐ Yes ☐ No

If yes, percentage of manual labour and/or work requiring physical effort: _____ %

3. EVALUATE YOUR INCOME

Net annual income (after expenses but before income tax): **$** _____

TO BE FILLED OUT ONLY IF YOU ARE A BUSINESS OWNER

Gross Income			
Gross business revenue		$	
Cost of goods	–	$	
Salaries and employee benefits (Except those of the Insured)	–	$	
Total **(1)**	=	$	0.00

Net Income			
Net business revenue		$	
Insured's salary	+	$	
Total **(2)**	=	$	0.00
The **ANNUAL INCOME** is the greater of 50% of **(1)** or 100% of **(2)**		$	0.00

4. POLICYHOLDER (To be completed if other than Insured)

Last name:	First name:
Email address:	SIN:
Date of birth: Y Y Y Y M M D D ☐ Save age	Gender: ☐ F ☐ M

Home address: ☐ Same as the Insured

Address: no.:	street:	apt.:
City:	Province:	Postal code:
Home/Cell telephone number:	Office telephone number:	Ext.:

5. BENEFICIARY (for AD&D and Overhead Expense Insurance)

Last Name	First Name	Gender	Distribution	Status*	Relationship to Primary Insured
		☐ F ☐ M	%	☐ Revocable ☐ Irrevocable	
		☐ F ☐ M	%	☐ Revocable ☐ Irrevocable	

* A beneficiary is always revocable unless designated specifically as irrevocable, with one exception: where Quebec's Civil Code applies, a beneficiary who is married to or in a civil union with the Primary Insured is always irrevocable unless designated specifically as revocable.

6. FAMILY COVERAGE

If you selected coverage for your spouse and/or children, please fill out this section for every dependent.

Last Name	First Name	Gender	Relationship	Date of birth
		☐ F ☐ M		Y Y Y Y M M D D
		☐ F ☐ M		Y Y Y Y M M D D

7. OTHER INSURANCE CONTRACT(S)

Do you currently hold any other insurance contract(s), excluding creditor group insurance? ☐ Yes ☐ No

Type	Company	Year Issued	Amount	Under Review	In Effect	To Replace*
☐ Life ☐ Disability			$	☐	☐	☐
☐ Life ☐ Disability			$	☐	☐	☐
☐ Life ☐ Disability			$	☐	☐	☐

*If the insurance applied for replaces any other insurance currently in force, you are required to attach the comparative statement (Quebec: disability and life / Outside Quebec: life only).

8. ELIGIBILITY - DISABILITY INSURANCE IN THE EVENT OF AN ACCIDENT OR SOFT TISSUE INJURY

1- Do you currently hold remunerative work for at least eight months per year and 21 hours per week? ☐ Yes ☐ No

2- Are you currently limited in terms of your movements or your daily activities due to an injury or illness? ☐ Yes ☐ No

3- Do you have a chronic neurodegenerative disease or a permanent physical or intellectual impairment? ☐ Yes ☐ No

⚠ **If the answer to question 1 is "NO" or if the answer to questions 2 or 3 is "YES", YOU ARE NOT ELIGIBLE for this product.**

9. ELIGIBILITY FOR DISABILITY INSURANCE IN THE EVENT OF AN ILLINESS

If you answer "**YES**" to any of the following medical and non-medical questions, **YOU ARE NOT ELIGIBLE** for disability insurance in the event of an **ILLNESS**.

A. MEDICAL QUESTIONS

1- Is your weight greater than the weight corresponding to your height in the following table? ☐ Yes ☐ No

Height/feet	Weight/pounds	Height/metres	Weight/kilograms
4'10" to 5'2"	210 lb	1.47 m to 1.58 m	95 kg
5'3" to 5'6"	234 lb	1.59 m to 1.68 m	106 kg
5'7" to 5'10"	264 lb	1.69 m to 1.78 m	119 kg
5'11" to 6'2"	294 lb	1.79 m to 1.88 m	133 kg
6'3" to 6'7"	324 lb	1.89 m to 2.01 m	146 kg

2- In your lifetime, have you suffered from or been treated for any of the following conditions:

a) Acquired immunodeficiency syndrome (AIDS) or tested positive for the human immunodeficiency virus (HIV)? ☐ Yes ☐ No

b) Heart attack (myocardial infarct), angina, heart valve disease, cerebrovascular disease (stroke), transient ischemic attack (TIA), aneurysm, or any other heart or blood vessel disorders? ☐ Yes ☐ No

c) Leukemia, lymphoma, malignant tumour or any other form of cancer (other than basal cell carcinoma)? ☐ Yes ☐ No

d) Crohn's disease, ulcerative colitis, chronic liver disease (including cirrhosis, fibrosis, hepatitis C or any other type of chronic hepatitis), or pancreatitis? ☐ Yes ☐ No

e) Polycystic kidney disease or kidney failure? ☐ Yes ☐ No

f) Type 1 diabetes or any of the following complications as a result of type 2 diabetes: eye disorders, peripheral nerve damage or kidney disorders? ☐ Yes ☐ No

3- Within the last five (5) years, have you suffered from or been treated for any of the following conditions:

a) Asthma which requires daily treatment, chronic bronchitis, emphysema, cystic fibrosis, sarcoidosis or sleep apnea? ☐ Yes ☐ No

b) Any kidney or genitourinary system disease requiring regular supervision (i.e. more than one visit per year) by your physician or a specialist? ☐ Yes ☐ No

c) Any type of arthritis (excluding osteoarthritis), any type of lupus, muscular dystrophy or degenerative disc disease, including herniated disc? ☐ Yes ☐ No

4- Within the last twelve (12) months:

a) If you have type 2 diabetes, has your medication changed as advised by a physician (addition or replacement of a medication, increase or decrease of dosage)? ☐ Yes ☐ No

b) Has an illness or injury resulted in absence from work for more than two consecutive weeks? ☐ Yes ☐ No

5- Presently, do you require regular supervision (i.e. more than one visit per year) by your physician or a specialist for all diseases or disorders of the eyes, ears, nose, throat, skin or blood? ☐ Yes ☐ No

6- Have you been advised to have any tests, consult with a physician (other than as part of a routine examination or government prevention program) or undergo surgery, that is still pending? ☐ Yes ☐ No

7- Has a member of your immediate family (father, mother, brother or sister) been diagnosed before the age of 60 with:

a) If you are a man: Colon cancer or familial adenomatous polyposis?

If you are a woman: Breast or ovarian cancer, colon cancer or familial adenomatous polyposis? ☐ Yes ☐ No

b) For all: Huntington's disease or polycystic kidney disease? ☐ Yes ☐ No

B. NON-MEDICAL QUESTIONS

1- Within the last five (5) years:

a) Have you used hard drugs or narcotics without a medical prescription? ☐ Yes ☐ No

b) Have you been treated for drug or alcohol use, joined a support group or been advised to reduce your consumption or to receive treatment for it? ☐ Yes ☐ No

2- Within the last twelve (12) months, have you been convicted of an offence or criminal act, or are you currently under indictment for an offence or criminal act, or has your license been suspended, withdrawn or restricted (for any reason other than unpaid tickets)? ☐ Yes ☐ No

10. SUMMARY OF REQUESTED COVERAGES

Occupational class ☐ C ☐ B ☐ 1A ☐ 2A ☐ 3A ☐ 4A

☐ LEVEL COMMISSION (default) ☐ UP-FRONT COMMISSION (not available for truck drivers)

DISABILITY INSURANCE IN THE EVENT OF AN ACCIDENT OR SOFT TISSUE INJURY

Waiting Period	**Coverage**		**Benefit Period**			**Additional Options**			**Sum Insured**	**Monthly Premium**
Number of days	24-hour	Non-work related	2 years	5 years	Up to age 70	Partial Disability	Return of Premiums	Extension of regular occupation (5 years)		
	☐	☐	☐	☐	☐	☐	☐	☐	$	$
	☐	☐	☐	☐	☐	☐	☐	☐	$	$
Overhead Expense Insurance									$	$

DISABILITY INSURANCE IN THE EVENT OF AN ILLNESS

Waiting Period	**Coverage**	**Benefit Period**			**Additional Options**			**Sum Insured**	**Monthly Premium**
Number of days	24-hour	2 years	5 years	Up to age 70	Partial Disability	Return of Premiums	Extension of regular occupation (5 years)		
	☐	☐	☐	☐	☐	☐	☐	$	$
	☐	☐	☐	☐	☐	☐	☐	$	$
Overhead Expense Insurance								$	$

OPTIONAL COVERAGE

Coverage	Sum Insured	Monthly Premium
Accidental death, dismemberment or loss of use (From $25,000 to $350,000 in increments of $25,000)		$
Accidental fracture (1 unit: $5,000, 2 units: $10,000)		$
Extended medical care further to an accident (Monthly premium: $2.50)	☐	$
Travel insurance Primary Insured: P Family: F	☐ P ☐ F	$
Policy fee		$ 2.50
A minimum annual premium of $100 applies to each contract. For an annual payment, monthly premium X 12.	**TOTAL**	$

11. METHOD OF PAYMENT

I hereby authorize Industrial Alliance Insurance and Financial Services Inc. ("iA Financial Group") to draw monthly payments from my bank account at my financial institution for the purpose of paying the insurance premium. This authorization concerns pre-authorized debits in the "personal" category. I will receive, at least ten days before any change in the date of the debit or in the amount to be debited, a notice to this effect. I will receive a notice in the event of insufficient funds ("NSF"), stop payment or account closed. Note that an administrative fee will apply to any dishonoured payment and will be payable at the same time as the returned amount and at the next regular payment. Note that the first pre-authorized debit will be adjusted to reflect the actual period between the first premium paid, the effective date of the coverages and the date I chose for the debits. Future debits will correspond to the monthly premium. I may cancel or change this pre-authorized debit agreement at any time, subject to providing iA Financial Group 30 days' notice in writing. I have certain recourse rights if any pre-authorized debit does not comply with this agreement. For example, I have the right to receive reimbursement for any debit that is not authorized or is not consistent with this agreement. To obtain a sample cancellation or reimbursement form or for more information on my recourse rights, I should contact my financial institution or visit www.payments.ca. For more information, please contact our Customer Service in Montreal at 1-800-465-5818 or by email at livingbenefits@ia.ca.

☐ Annual premium ➜ Please make your cheque out to iA Financial Group

FIRST PREMIUM

☐ Cheque attached made out to iA Financial Group.

☐ Pre-authorized debit (upon receipt of application)

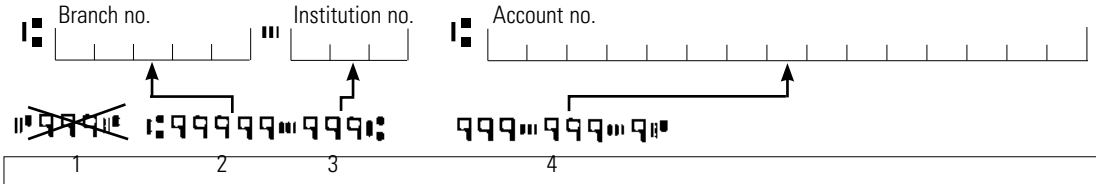
SUBSEQUENT PREMIUMS

☐ Pre-authorized debit on the _____ of each month (1st to 28th)

If no date is given, premium will be withdrawn on effective date of the contract.

Please attach a specimen cheque marked "Void"

OR please give us the name of your financial institution: _____



1 Cheque number (do not write this number).

2 Branch number (5 digits).

3 Financial institution number (3 digits).

4 Account number. The format may vary from one financial institution to another. Indicate all numbers and only the numbers.

_____ **X** _____ Y Y Y Y M M D D

Last name and first name of payor | Signature (as it appears on cheques) | Date

12. DECLARATION

I understand and accept that:

1. the information provided in this application is true and complete and acknowledge that it constitutes the basis for insurance coverage;
2. if any misrepresentation or omission is made, the Insurer shall not be held to any obligation under any insurance that may be issued to me further to acceptance of my insurance application;
3. all benefits payable are subject to the conditions, definitions, limitations and exclusions set out in the contract. I further confirm that my representative has had the opportunity to explain the details of the contract to me;
4. disability insurance will take effect the same day the application is received at the Insurer's Montreal office. Coverage will take effect only if the first premium has been paid and payment is honoured upon initial presentation;
5. I undertake to inform the Insurer of any change in my insurability, including my health, between the time of signature of this application and the date the requested contract will be in force;
6. iA Financial Group, its affiliates and their agents can access information about me in order to know me better, better meet my 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.)

Signed at: _____ on Y Y Y Y M M D D

X _____
Signature of primary insured

X _____
Signature of policyholder
(if other than primary insured)

X _____
Signature of representative

13. AUTHORIZATION TO COLLECT AND COMMUNICATE PERSONAL INFORMATION TO THIRD PARTIES

I hereby authorize any healthcare professional as well as any other public or private health or social service establishment or organization, any insurance company, MIB LLC, financial institutions, personal information agents, professional investigation agencies or any credit reporting agency and any public body holding personal information concerning myself, including medical information, to supply this information to iA Financial Group and its reinsurers for the risk assessment, the investigation necessary for the study of any claim or the management of my file(s). A photocopy or electronic version of this authorization is as valid as the original.

_____
Last name and first name of Primary Insured

X _____
Signature of Primary Insured

Y Y Y Y M M D D
Date

14. PRE-NOTICE FROM MIB LLC

The primary objective of the Company is to provide its clients with financial security at the lowest possible cost. In order to achieve this goal in a fair and equitable manner with respect to all policyholders, the Company must assess the risk associated with every insurance application. Your application is reviewed based on information from various sources of data that you have provided regarding your medical history, the results of any medical examination or test deemed necessary, reports received from the physicians you consulted and the hospitals where you stayed as a patient, as well as information regarding your character, your financial reputation, your personal expenses and your lifestyle.

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 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.

CONSTITUTION OF A FILE AND PROTECTION OF PERSONAL INFORMATION

For the purpose of offering you insurance, annuity, credit or other complementary products that may respond to your needs, iA Financial Group will establish a file in which your personal information will be kept.

This file will remain strictly confidential and will be kept in the offices of iA Financial Group. Only employees or representatives who need this information as part of their duties will have access to this file.

You are entitled to access the personal information contained in this file and, if necessary, to have it rectified by sending a written request to the following address: Industrial Alliance Insurance and Financial Services Inc., Chief Privacy Officer, 1080 Grande Allée West, PO Box 1907, Station Terminus, Quebec City, QC G1K 7M3.

iA Financial Group may establish a list of its clients for its own commercial prospecting purposes or those of the other companies in its group. However, you are entitled to have your name removed from this list by making a written request to this effect to the Chief Privacy Officer at the address indicated above.