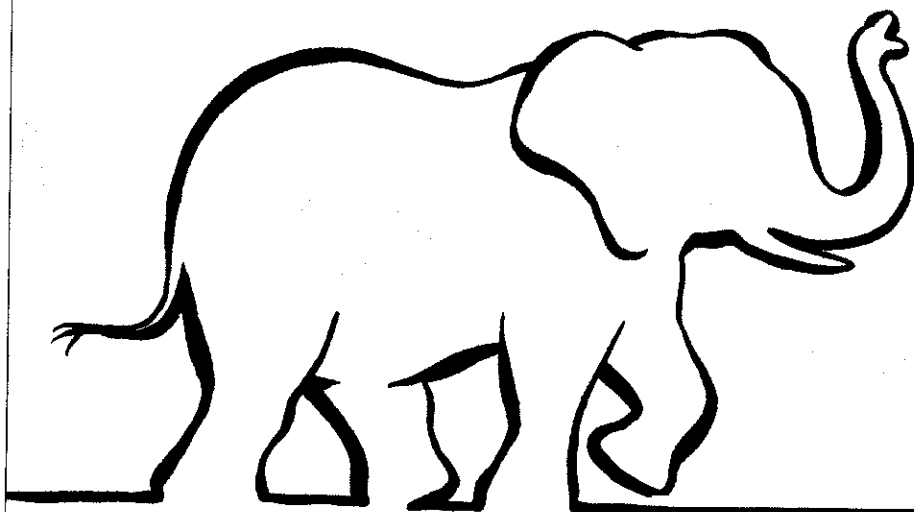


# LIFE INSURANCE APPLICATION



IN LINE WITH YOUR LIFE<sup>®</sup>



**INDUSTRIAL ALLIANCE**  
INSURANCE AND FINANCIAL SERVICES INC.



**PROPOSED INSURED** WRITE LEGIBLY IN BLOCK LETTERS

**1 Last name and first name** Last name \_\_\_\_\_ First name \_\_\_\_\_

**2 Address** No. \_\_\_\_\_ Street \_\_\_\_\_ Apartment \_\_\_\_\_ PO Box \_\_\_\_\_  
City \_\_\_\_\_ Province \_\_\_\_\_ Postal code \_\_\_\_\_

**3 Date of birth and age at nearest birthday** Date of birth \_\_\_\_\_ Age \_\_\_\_\_ Sex  M  F Last name at birth (if applicable) \_\_\_\_\_ Place of birth (province or country) \_\_\_\_\_ When did you arrive in Canada? \_\_\_\_\_  
D M Y  Conserve the age  Since birth OR M Y

**4 Telephone** Home phone no. \_\_\_\_\_ Phone number at work \_\_\_\_\_ Extension \_\_\_\_\_ Electronic address (E-mail) \_\_\_\_\_

**5 Occupation and SIN** Present occupation \_\_\_\_\_ Since when? \_\_\_\_\_ Gross annual income \_\_\_\_\_ Net worth \_\_\_\_\_  
M Y \$ \$  
Type of business \_\_\_\_\_ Employer's name and address \_\_\_\_\_  
Previous occupation for a two-year period (if at present occupation for less than 2 years) \_\_\_\_\_ Health insurance no. (optional) \_\_\_\_\_ Social Insurance Number \_\_\_\_\_

**APPLICANT (if different than proposed insured)** For joint insurance, both insureds are applicants, unless otherwise indicated in the section below.

**1 Last name and first name** Last name \_\_\_\_\_ First name \_\_\_\_\_

**2 Address** No. \_\_\_\_\_ Street \_\_\_\_\_ Apartment \_\_\_\_\_ PO Box \_\_\_\_\_  
City \_\_\_\_\_ Province \_\_\_\_\_ Postal code \_\_\_\_\_

**3 Date of birth and age at nearest birthday** Date of birth \_\_\_\_\_ Age \_\_\_\_\_ Sex  M  F When did you arrive in Canada? \_\_\_\_\_ Relationship to proposed insured \_\_\_\_\_  
D M Y  Since birth OR M Y

**4 Telephone** Home phone no. \_\_\_\_\_ Phone number at work \_\_\_\_\_ Extension \_\_\_\_\_ Electronic address (E-mail) \_\_\_\_\_

**5 Occupation and SIN** Present occupation \_\_\_\_\_ Annual income \_\_\_\_\_ Social Insurance Number \_\_\_\_\_ Insurance in force \_\_\_\_\_  
\$ \$

**6 Contingent Policyowner** Last name \_\_\_\_\_ First name \_\_\_\_\_

**BENEFICIARY - LIFE INSURANCE**

**1 Last name and first name** Last and first name \_\_\_\_\_ Sex \_\_\_\_\_ Date of birth \_\_\_\_\_ % \_\_\_\_\_ Relationship to proposed insured \_\_\_\_\_  
 M  F D M Y  Revocable  Irrevocable

**2 For MERIDIA (required)** The beneficiary of the accumulation fund is:  the beneficiary or beneficiaries named in this section  the applicant  Revocable  Irrevocable  
The lack of a designation constitutes a revocable designation in favour of the beneficiary or beneficiaries named in this section.  Revocable  Irrevocable

**3 Contingent Beneficiary** For 1<sup>st</sup> beneficiary \_\_\_\_\_  Rev.  Irrev. For 2<sup>nd</sup> beneficiary \_\_\_\_\_  Rev.  Irrev. For 3<sup>rd</sup> beneficiary \_\_\_\_\_  Rev.  Irrev.

**BENEFICIARY - CRITICAL ILLNESS**

**1 Beneficiary of the benefits in the event of critical illness** Last and first name \_\_\_\_\_ Sex \_\_\_\_\_ Date of birth \_\_\_\_\_ % \_\_\_\_\_ Relationship to proposed insured \_\_\_\_\_  
 Applicant or  M  F D M Y  Revocable  Irrevocable

**2 Beneficiary of the premium return at death (except Home Protection Plan)** Last and first name \_\_\_\_\_ Sex \_\_\_\_\_ Date of birth \_\_\_\_\_ % \_\_\_\_\_ Relationship to proposed insured \_\_\_\_\_  
 M  F D M Y  Revocable  Irrevocable

**AGENT**

Last and first name \_\_\_\_\_ Agent number \_\_\_\_\_ S.U. \_\_\_\_\_ % \_\_\_\_\_ Agency name \_\_\_\_\_ Agency code \_\_\_\_\_

**REQUESTED COVERAGE**

**1 Purpose • Feature**

**Purpose of insurance**

- Personal insurance  
 Business insurance  
 Key person  
 Purchase of shares  
 Other \_\_\_\_\_

**Joint insurance**

- First to die  
 Last to die  
 Last to die, paid-up on first death  
 Complete an Addition of Coverage form

**Optional or additional**

- Optional  
 Additional  
 Other application no. \_\_\_\_\_

**Preliminary**

- Heart problems, diabetes, cancer, declined or postponed

**2 Plan • Rider**



For Meridia, provide a complete illustration (all pages) signed by the client.

**Permanent life coverage**

\$ \_\_\_\_\_

**Term life coverage**

Renewable and convertible

Non-renewable and non-convertible

T10 R&C \$ \_\_\_\_\_  
T20 R&C \$ \_\_\_\_\_

T10 \$ \_\_\_\_\_  
T20 \$ \_\_\_\_\_

**Critical illness term coverage**

T10 R Critical Illness \$ \_\_\_\_\_  
T75 Critical Illness \$ \_\_\_\_\_  
Child Critical Illness \$ \_\_\_\_\_

If a paramedical is not required, complete the Q4A questionnaire.  
Complete an addition of coverage form for each child, as well as the Q4A questionnaire.

**Interest Bonus**

- Variable interest bonus  
 Guaranteed interest bonus

If no instructions are given, we will use the variable interest bonus.

Cost of insurance  Level  Annual (YRT)

Option  10 yrs  15 yrs  20 yrs

**Death benefit**

- Face amount  
 Face amount plus fund  
 Face amount plus fund with Wealth Maximizer Option

Wealth maximizer

- No reduction for the first \_\_\_\_\_ years (minimum 10 years)
- \$ \_\_\_\_\_ floor face amount (minimum \$10,000)  
If no instructions are given, the Wealth Maximizer Option is not exercised.
- No reduction for the first \_\_\_\_\_ years (minimum 5 years)
- \$ \_\_\_\_\_ floor face amount (minimum \$10,000)  
If no instructions are given, we will use 5 years and \$10,000.

**On the Applicant** (complete declaration of insurability)

CAD \$ \_\_\_\_\_ /month Contribution in the event of Applicant's Disability  
 or  CAD = minimum premium

CADE \$ \_\_\_\_\_ /month Contribution in the event of Applicant's Death CID \$ \_\_\_\_\_ /month Contribution in the event of Insured's Disability  
 or  CADE = minimum premium

**Automatic Investment Instructions** (Maximum 5; if no instructions are given, we will use the 5-year average account)

Guaranteed interest accounts		Market index accounts				Active management accounts		Other	
	%		%		%		%		%
5-year Average	_____	Money market	_____	International Stocks	_____	Prudent account	_____	Canadian Stocks (Bissett)	_____
3-year Term	_____	Bonds	_____	European Stocks	_____	Moderate account	_____	Canadian Stocks (Fidelity)	_____
5-year Term	_____	Canadian Stocks	_____	U.S. Stocks	_____	Balanced account	_____	International Stocks (Templeton)	_____
10-year Term	_____	Global Stocks	_____	U.S. Stocks / DAQ	_____	Growth account	_____	U.S. Stocks (AGF)	_____
						Aggressive account	_____	U.S. Stocks (Legg Mason)	_____

The Company reserves the right to reimburse deposits at their market value if the contract is refused by the client.

**MAXIRANCE**

**Term coverage**

**Permanent Protection**

L10 \$ \_\_\_\_\_

L20 \$ \_\_\_\_\_

L100 \$ \_\_\_\_\_

Renewable and convertible

T10 R&C \$ \_\_\_\_\_

T20 R&C \$ \_\_\_\_\_

Non-renewable and non-convertible

T10 \$ \_\_\_\_\_

T20 \$ \_\_\_\_\_

**On the Applicant** (complete declaration of insurability)

- WPDIs  WPD  10 years  15 years  20 years  to age 55  
 to age 60  to age 65  For life

Home **Protection** Plan

**Mortgage insurance**

\$ \_\_\_\_\_

**Attach the amortization schedule.**

- Life  
 **Critical Illness** (If a paramedical is not required, complete the Q4A questionnaire)  
 **Disability 100%\***  **Disability 50%\***  
 2 years or until the end of the mortgage (Maximum age 65)

**On the applicant** (Complete declaration of insurability)

- WPDIs for life \*Maximum benefit of \$5,000 per month

**TRANSITION**

**Critical Illness Product**

\$ \_\_\_\_\_ If a paramedical is not required, complete the Q4A questionnaire.

- Transition T10 R  Transition T10 R with Flexible Premium Reimbursement  
 Transition T75  Transition T75 with Flexible Premium Reimbursement  
 Transition T100 with Flexible Premium Reimbursement

**Rider and benefit**

- Transition child  
 Complete an addition of coverage form and questionnaire Q4A. \$ \_\_\_\_\_

**On the applicant** (Complete declaration of insurability)

- WPDIs for life

**Other Plan**

\$ \_\_\_\_\_

**Child Module**

\$ \_\_\_\_\_

Complete an Addition of Coverage form for each child.

**On the proposed insured**

AD \$ \_\_\_\_\_

AD&D \$ \_\_\_\_\_

GI \$ \_\_\_\_\_

Fracture

**3 Additional benefits**

**PREMIUM BILLING**

Minimum premium (MERIDIA) or  
Modal premium (other products)

\$

Target premium (MERIDIA)

\$

Amount paid

\$

Or

Target premium = minimum premium

Make the cheque payable to the  
order of Industrial Alliance.

Method of payment

PAC  ANNUAL  SEMIANNUAL\*  QUARTERLY\*  PAC / COD (payable on delivery, amendment to be signed)

\* Not available with MERIDIA and Transition

**TOBACCO**

Have you used any kind of tobacco in the past twelve months including nicotine or tobacco products (gum, patch, etc.)?

Yes => Smoker rate  No => Non-smoker rate (answer the following question)

• Have you ever used tobacco?  Yes  No

• If yes, when did you quit? 

M	Y
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**RISK CLASS FOR PLANS OR RIDERS WITH \$100,000 OR MORE OF LIFE INSURANCE**

- The premium corresponds to the risk class:
  - Elite non-smoker  Elite smoker
  - Preferred non-smoker  Preferred smoker
  - Non-smoker  Smoker

• If the risk class determined by the Company does not correspond to the one indicated here after your file is underwritten, do you want to:

- Maintain the same face amount and modify the premium in consequence. For a PAC mode of payment, I authorize Industrial-Alliance to collect the pre-authorized payment (PAC) that corresponds to the adjusted premium.
- Maintain the same premium and modify the face amount in consequence
- Other instructions (specify)

If no instructions are given, we will use the first option: maintain the face amount and modify the premium.

**OTHER INSURANCE**

1. Does the proposed insured have another insurance application pending?  Yes  No

If yes: 

D	M	Y

 Name of the company

D	M	Y

2. Has the proposed insured ever been declined or had an application modified or postponed?  Yes  No

If yes:  Reason 

D	M	Y

 Name of the company

D	M	Y

3. Insurance in-force for the proposed insured  None

Amount of Life insurance	Amount of critical illness insurance	Amount of disability insurance	Year of issue	With Industrial Alliance policy no.	With another company Name of company	Will the proposed insurance totally or partially replace this life insurance policy?
\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/> / month	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/> / month	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/> / month	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/> / month	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No

If the requested insurance replaces an Industrial Alliance policy, complete an F4A or F6A.

**REQUIREMENTS**

Have you arranged medical requirements?  
 No  Yes => Name of paramedical organization

Requirements

Urine -HIV  Blood profile  Paramedical examination  EKG  Stress EKG

If yes, reference no.

**SPECIAL INSTRUCTIONS**

Insured's last name

Insured's first name

DECLARATION OF INSURABILITY

Proposed insured

Applicant with

For all "yes" answers, give details below specifying the name of the person involved.

Optional if paramedical Yes No

WPD's, WPD, CAD, CADE Yes No

1 Within the past five years, have you consulted a physician, chiropractor or other practitioner, undergone a medical examination or been treated in a hospital, clinic or other medical facility?

If yes provide details and answer question 2

Description of the ailments prompting the consultation Names, addresses and phone numbers of physicians and hospitals consulted Consultation dates (frequency)

2 a) Health problem control or follow-up exams (nature of the problem, date of diagnosis, last control date)

b) Hospitalization (duration)

c) Treatments received (type and duration)

d) Medication prescribed (name, dosage, duration and date last taken)

e) Diagnostic examinations electrocardiograms X-rays blood tests (nature, date, results) other (Specify)

f) Follow-up examinations recommended (nature and date)

g) Disability or absence from work (causes, dates, duration)

3 Have you consulted or been treated for pain or discomfort in the back, neck or joints (frequency, dates, causes)

4 Have you tested positive for an AIDS screening test or for Hepatitis B or C? (Specify)

5 Do you have any physical or mental abnormalities?

6 Do you take medication prescribed by a physician? (name, reason, dosage)

7 Has any family member (father, mother, brother, sister, spouse, children) suffered from, or is suffering from diabetes, heart disease or mental illness, Huntington's disease, Steinert's disease or AIDS? (Give age at diagnosis, actual age if living or age at death)

8 a) Do you follow a diet prescribed by a physician?

b) Have you lost or gained weight by more than 10% in the last year? (If yes, specify the gain or the loss and the reason)

9 Have you made or do you intend to make aerial flights other than as a passenger? (If yes, complete an Aviation Questionnaire Q1A)

10 During the past two years, have you taken part in any hazardous sports, such as parachuting, scuba diving, bungee jumping, mountain climbing, hang-gliding, gliding, automobile, motorcycle or motocross racing, etc.? (If yes, complete a Hazardous Sports Questionnaire Q1A)

11 Do you intend to travel or reside outside Canada or the United States for more than a month? (If yes, complete a Foreign Residence Questionnaire Q1A)

12 Within the past three years, have you: (If one of the answers is yes, complete a Driving Record Questionnaire Q1A)

a) been convicted of five infractions or more under the Highway Traffic Act?

b) had your driver's licence suspended or withdrawn (If yes, give reason)

c) been convicted or do you have any charges pending for driving while impaired? (if yes, give dates)

13 Within the past 10 years, have you used drugs, narcotics or steroids? (If yes, complete a Drug Questionnaire Q1A)

14 Do you or have you ever used alcohol?

If yes, answer the following questions:

(1 Unit = 1 glass of wine = 1 bottle of beer = 1 ounce of alcohol)

a) Current number of units and frequency:

b) If there has been a reduction of alcohol consumption, enter the number of units and frequency before the reduction: (Specify date and reason)

c) Have you ever received treatment for alcohol use? (date and name of physician or institution)

d) Have you ever been a member of a support group? (such as Alcoholics Anonymous)

15 Height and weight

ft cm lbs kg

SIGNATURES AND AUTHORIZATIONS

We, the proposed insured and the applicant, declare that all answers and explanations given in this application, or in any other questionnaire in connection herewith or during any interview, by telephone or otherwise, with respect to our declaration of insurability are true and complete.

We agree that the insurance takes effect as of the acceptance of the application by Industrial-Alliance Life Insurance Company 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 Industrial-Alliance will rely upon, among other things, said declaration in determining whether to accept the application.

We hereby authorize any health care professional as well as any other public or private health or social service establishment, any insurance company, the Medical Information Bureau, financial institutions, personal information agents or professional investigation agencies and any public body holding information concerning ourselves or our family, We agree that a photocopy of this authorization is as valid as the original.

Signed at

this

day of

Proposed insured (if aged 16 years or over)

Applicant(s)

Agent

X

X

X

X

X

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 and its reinsurers for the risk assessment or the investigation necessary for the study of any claim.

We also authorize our insurer, or its reinsurers, to exchange with its subsidiaries and other insurers or financial institutions, the personal information obtained for the purposes of studying this application 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.

We also authorize the Industrial-Alliance Life Insurance Company to release any abnormal test results to our personal physician.

In case of death or disability, the beneficiary, the heir or the liquidator of my estate, is expressly authorized to supply Industrial-Alliance Life Insurance Company, when required by the latter, with all information and authorizations necessary to study the death benefit or disability claim and obtain the required documentation.

**PRE-AUTHORIZED CHEQUE**

Attach specimen cheque to the other side

1 Do you already pay by Pre-Authorized Cheque

- No Complete items 3 to 6, sign and attach specimen cheque to the other side.
- Yes Complete items 2 and 4 and sign.

2 Authorization no.

3 Account no.

4 Date of cheque  Same as the existing group  Effective date  Day \_\_\_\_\_ (1 to 28) for this contract or new group

5 Policy no(s) to be included with the plan

6 Name as shown on bank records (include all names if joint account)

Industrial-Alliance Life Insurance Company is authorized to draw a cheque each month in accordance with its Pre-Authorized Cheque plan and exchange personal information with the financial institution to execute this agreement.

Signature (as shown on bank records)

Other signature (Joint account)

X

X

Note: Transaction fees may be charged for any cheques returned by your financial institution.

**AUTHORIZATION**

We hereby authorize any health care professional as well as any other public or private health or social service establishment, any insurance company, the Medical Information Bureau, 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 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 \_\_\_\_\_

Proposed insured

Applicant

Witness

X

X

X

We hereby authorize any health care professional as well as any other public or private health or social service establishment, any insurance company, the Medical Information Bureau, 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 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 \_\_\_\_\_

Proposed insured

Applicant

Witness

X

X

X



Application no.

A312887

**BINDING RECEIPT IN THE EVENT OF DEATH AND CRITICAL ILLNESS**

Each proposed insured is covered by temporary insurance starting on the signature date on the insurance application presented to Industrial-Alliance and bearing the same number and date as the binding receipt, under the conditions and limitations described below.

**MAXIMUM FACE AMOUNT**

The maximum amount payable under the terms of this notice and any other similar agreements in force with the Company shall be equal to the amount of insurance applied for excluding the bonuses, if applicable, but shall not exceed a total amount of \$500,000 including the accidental death benefits.

**GENERAL CONDITIONS**

An amount equal to the first monthly premium must be deposited when the application is signed even if an authorization for the preauthorized cheque system (PAC) is submitted to the Company.

The changes in the state of health, occupation or insurability of each proposed insured, occurring after the application was signed, are not covered by this binding receipt.

**TERMINATION OF INSURANCE COVERING EACH PROPOSED INSURED**

The binding receipt terminates when the first of the following events occurs:

- the date the Company decides to accept the risk with or without modifications, postpone it, decline it or cancel the application.
- the date on which the applicant requested its cancellation;
- the 90th day after this application is signed.

**SPECIFIC CONDITIONS AND LIMITATIONS**

In the event of death, if life insurance coverage is applied for.

- Each proposed insured is covered for accidental death or death by natural causes on condition that he/she has not been affected or he/she has not consulted or been treated for the illness that led to his/her death.
- No amount is payable:
  - for the coverage other than death coverages;
  - for Home Protection Plan, if the Critical Illness benefit has already been paid;
  - if the proposed insured commits suicide, whether conscious of the act or not;
  - if death occurs while the proposed insured commits or attempts to commit a criminal act or provokes a criminal act.

In the event of critical illness, if critical illness coverage is applied for.

- Each proposed insured is covered for critical illness on condition that he/she has not been affected or he/she has not consulted or been treated for a disorder or an illness that led to the diagnosis of critical illness.
- The proposed insured must survive for at least 30 days after he/she has been diagnosed with a critical illness, except if the coverage requested is Home Protection Plan-Critical Illness.
- No amount is payable:
  - if the proposed insured is diagnosed with cancer;
  - if the proposed insured is suffering or has suffered from a critical illness;
  - if the critical illness occurs while the proposed insured self-inflicts injuries or attempts to commit suicide, whether conscious of the act or not;
  - if the critical illness occurs while the proposed insured commits or attempts to commit a criminal act or provokes a criminal act.

Signed at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_

day of

Agent's signature

X

