LIFE INSURANCE

CRITICAL ILLNESS INSURANCE

Application no.

WARNING

This form had been designed to be used exclusively with an Adobe for Windows product such as Adobe Reader.

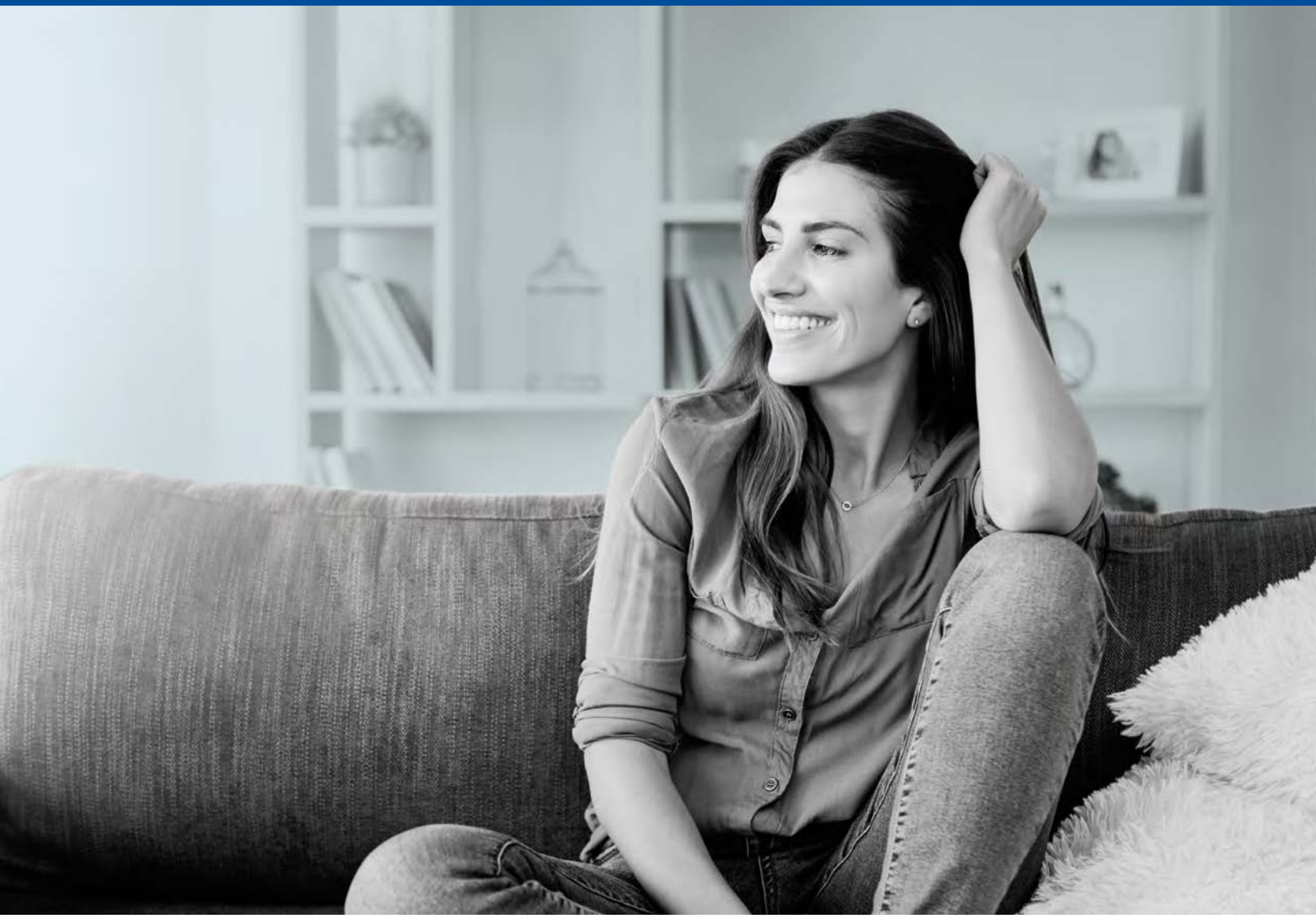
Please close this form, save on your Windows desktop, and open from the Adobe Reader application.

Print

Save a copy

Finalize !

F1A APPLICATION



iA Financial Group

Client name(s)

F1A (25-05) ACC

iA Financial Group ia.ca

TABLE OF CONTENTS

Additional documents to provide (if applicable):

- ☐ Mandatory illustration for GENESIS, LEGACY and iA PAR
- ☐ Investor profile for GENESIS and LEGACY
- ☐ F3A form for an additional insured
- ☐ F6A or F4A form for a total or partial surrender
- ☐ Cheque to pay the first premium

iA Financial Group ia.ca

F1A

POLICY NO. (for internal use)

Application no.

1 PROPOSED INSURED (For additional insured, please complete F3A.) *(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 wish to save the insured's actual age, indicate the age to save: _____
The policy and premiums will be established based on the indicated age, in accordance with applicable underwriting rules and subject to payment of retroactive premiums.

For Genesis, Legacy and iA PAR policies only (to be completed only if the insured is also the applicant)

Main occupation (Be specific, terms such as "manager" are not sufficient):

Name of employer:

B Address

⚠ **Always mandatory (If it is not possible to provide a street address, please provide a copy of an identification document with proof of address.)**

No. Street | Apartment/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

This page
has
intentionally
been left blank.

PERSONAL INFORMATION CONSENTS

Your personal information is important.

For **you**, because it involves your privacy. For **us**, iA Financial Group and its affiliates, because it allows us to better serve you day by day.

Protecting your personal information is important to us.

By doing business with us, you agree to the collection, use and disclosure of personal information necessary to:

- **Know who you are.** Identify you and keep your contact information up to date.
- **Build a relationship with you.** Advise you according to your needs, analyze your requests and identify the products and services that are right for you.
- **Maintain our relationship with you.** Administer your products and services and process your requests, complaints and claims.
- **Comply with the laws and manage risk.** For instance, with regard to cybersecurity or the fight against financial crime.

We would like to do more, with your consent of course!

We wish to collect, use and disclose some of your personal information to get to know you better and understand your needs, interests and preferences. By agreeing, you enable us to be proactive in:

Improving our products and services and providing a distinctive client experience.

☐ **I agree** ☐ **I decline**

Keeping you informed of our promotions, products, services, contests and events that may be of interest to you.

☐ **I agree** ☐ **I decline**

You may review your choices at any time.
For more information, please visit ia.ca/protection-personal-information.

Last name: _____ **First name:** _____

Email: _____ **Phone:** |_|_|_|_|_|_|_|_|_|_|

We want to inform you.

Under certain conditions, we may collect or disclose your personal information with regulatory authorities and self-regulatory bodies and courts, public bodies, credit reporting and reporting agencies, organizations that maintain public information databases or insurance information offices, insurers and financial institutions, investigative organizations, employers, trade unions and associations, iA Financial Group's affiliated entities and their representatives, intermediaries in the distribution of our financial products and services, service providers when applicable, or any other third party, **if and only if** this collection or disclosure:

- is necessary to serve you, or
- is made in respect of the choices you have made, or
- is in accordance with the law.

We are committed to sharing only necessary information.

To learn more, please refer to the **Privacy Notice** attached.

F13-1229A(23-07) ACC

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 in force

Do you have in-force insurance on your life, excluding group insurance or credit insurance? ☐ YES ☐ NO

If YES, please provide the following information:

Main insured

Name of company	Surrender of contract?	Policy number (iA contract)	Amount of life insurance	Amount of critical illness insurance	Amount of disability insurance	Year of issue	Need
	☐ Yes* ☐ No		$	$	$	Y Y Y Y	☐ Personal ☐ Business
	☐ Yes* ☐ No		$	$	$	Y Y 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).

3 LINKED APPLICATIONS

A Additional applications (applications to be issued simultaneously with this application, and for the same insured)

Main insured

Full name of the main insured: _____

Application number

Additional insured

Full name of the additional insured	Application number

B Linked applications (other applications to be issued simultaneously with this application such as for family members or business partners)

Full name of the applicant	Application number

4 APPLICANT

For individual insurance, the main insured is the applicant, unless otherwise indicated below.
For joint insurance, all joint insureds are applicants, unless otherwise indicated below.
For a Multilife application, please specify the applicant (in the absence of any indication, the main insured is by default considered applicant).

Please specify the applicant: ☐ Main insured ☐ Additional insured ☐ Other (If other, please complete the section below.)

A Identification (For corporations, please indicate the organization's name and the place of incorporation.)

Last name | First name | Middle name

Sex ☐ M ☐ F | Date of birth Y Y Y Y M M D D | Age | Social Insurance Number – Optional

For Genesis, Legacy and iA PAR policies only

If the applicant is an individual: Main occupation (Be specific, terms such as "manager" are not sufficient):

Name of employer:

If the applicant is an organization: Business sector (Be specific):

B Address

⚠ **Always mandatory (If it is not possible to provide a street address, please provide a copy of an identification document with proof of address.)**

☐ Same address as the Main Insured

No. | Street | Apartment/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

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

E Contingent owner

Last name | First name

Sex ☐ M ☐ F | Date of birth Y Y Y Y M M D D

PERSONAL INFORMATION CONSENTS

Your personal information is important.

For **you**, because it involves your privacy. For **us**, iA Financial Group and its affiliates, because it allows us to better serve you day by day.

Protecting your personal information is important to us.

By doing business with us, you agree to the collection, use and disclosure of personal information necessary to:

- **Know who you are.** Identify you and keep your contact information up to date.
- **Build a relationship with you.** Advise you according to your needs, analyze your requests and identify the products and services that are right for you.
- **Maintain our relationship with you.** Administer your products and services and process your requests, complaints and claims.
- **Comply with the laws and manage risk.** For instance, with regard to cybersecurity or the fight against financial crime.

We would like to do more, with your consent of course!

We wish to collect, use and disclose some of your personal information to get to know you better and understand your needs, interests and preferences. By agreeing, you enable us to be proactive in:

Improving our products and services and providing a distinctive client experience.

☐ **I agree** ☐ **I decline**

Keeping you informed of our promotions, products, services, contests and events that may be of interest to you.

☐ **I agree** ☐ **I decline**

You may review your choices at any time.
For more information, please visit ia.ca/protection-personal-information.

Last name: _____ **First name:** _____

Email: _____ **Phone:** |_|_|_|_|_|_|_|_|_|_|

We want to inform you.

Under certain conditions, we may collect or disclose your personal information with regulatory authorities and self-regulatory bodies and courts, public bodies, credit reporting and reporting agencies, organizations that maintain public information databases or insurance information offices, insurers and financial institutions, investigative organizations, employers, trade unions and associations, iA Financial Group's affiliated entities and their representatives, intermediaries in the distribution of our financial products and services, service providers when applicable, or any other third party, **if and only if** this collection or disclosure:

- is necessary to serve you, or
- is made in respect of the choices you have made, or
- is in accordance with the law.

We are committed to sharing only necessary information.

To learn more, please refer to the **Privacy Notice** attached.

F13-1229A(23-07) ACC

PERSONAL INFORMATION CONSENTS

Your personal information is important.

For **you**, because it involves your privacy. For **us**, iA Financial Group and its affiliates, because it allows us to better serve you day by day.

Protecting your personal information is important to us.

By doing business with us, you agree to the collection, use and disclosure of personal information necessary to:

- **Know who you are.** Identify you and keep your contact information up to date.
- **Build a relationship with you.** Advise you according to your needs, analyze your requests and identify the products and services that are right for you.
- **Maintain our relationship with you.** Administer your products and services and process your requests, complaints and claims.
- **Comply with the laws and manage risk.** For instance, with regard to cybersecurity or the fight against financial crime.

We would like to do more, with your consent of course!

We wish to collect, use and disclose some of your personal information to get to know you better and understand your needs, interests and preferences. By agreeing, you enable us to be proactive in:

Improving our products and services and providing a distinctive client experience.

☐ **I agree** ☐ **I decline**

Keeping you informed of our promotions, products, services, contests and events that may be of interest to you.

☐ **I agree** ☐ **I decline**

You may review your choices at any time.
For more information, please visit ia.ca/protection-personal-information.

Last name: _____ **First name:** _____

Email: _____ **Phone:** |_|_|_|_|_|_|_|_|_|_|

We want to inform you.

Under certain conditions, we may collect or disclose your personal information with regulatory authorities and self-regulatory bodies and courts, public bodies, credit reporting and reporting agencies, organizations that maintain public information databases or insurance information offices, insurers and financial institutions, investigative organizations, employers, trade unions and associations, iA Financial Group's affiliated entities and their representatives, intermediaries in the distribution of our financial products and services, service providers when applicable, or any other third party, **if and only if** this collection or disclosure:

- is necessary to serve you, or
- is made in respect of the choices you have made, or
- is in accordance with the law.

We are committed to sharing only necessary information.

To learn more, please refer to the **Privacy Notice** attached.

F13-1229A(23-07) ACC

5 REGULATORY QUESTIONS

The following questions and the organization classification are required for the purpose of compliance with the Proceeds of Crime (Money Laundering) and Terrorist Financing Act and Regulations, with the Common Reporting Standard (CRS) and with the U.S. Foreign Account Tax Compliance Act (FATCA).

A PREMIUM FINANCING – ALWAYS MANDATORY

1) Will the life insurance premiums be financed and/or paid by a lender or any other person who has no relationship with the insured person? ☐ YES ☐ NO

If YES, indicate the name of the lender or the other person: _____

B TO BE COMPLETED FOR INDIVIDUAL APPLICANTS – For applicants that are organizations, see section C on the next page.

I. TAXATION - ALWAYS MANDATORY

2) Is one of the applicants a U.S. citizen or a U.S. resident for U.S. tax purposes? ☐ YES ☐ NO

If YES, specify the name and the taxpayer identification number (TIN) or SSN of the applicant(s).

Name _____ TIN or SSN _____

Name _____ TIN or SSN _____

3) Is one of the applicants a tax resident in a jurisdiction other than Canada or the United States? ☐ YES ☐ NO

If YES, specify the name, the jurisdiction(s) of tax residence and taxpayer identification number(s) (TIN) of the applicant(s).

Name _____ Jurisdiction _____ TIN _____

Name _____ Jurisdiction _____ TIN _____

II. ANTI-MONEY LAUNDERING - FOR GENESIS, LEGACY AND iA PAR POLICIES ONLY

4) Is the applicant acting on the instructions of an undisclosed individual or organization (a third party)? ☐ YES ☐ NO

A third party includes, but is not limited to, the following:
- a person contributing funds to this contract **who is not the applicant/owner**
- an attorney appointed under a power of attorney
- an undisclosed individual or organization that is instructing the applicant/owner

If YES, the instructions are provided by (provide name): _____

☐ An individual → Date of birth: Y Y Y Y M M D D

☐ A corporation → Incorporation number: _____ Place of incorporation: _____

☐ Another type of organization (please specify): _____

Relationship to applicant: _____

Address (not only a P.O. box number): _____

_____

Telephone number: _____

Occupation / Type of business (be specific): _____

5) What is the source of funds used to pay the premiums of this insurance?

☐ Employment income/salary ☐ Retirement income/pension ☐ Business income ☐ Investments ☐ Savings ☐ Loan ☐ Inheritance

☐ Other (provide details): _____

6) Will a lump-sum payment of $100,000 or more be made on this policy? ☐ YES ☐ NO

If YES, please complete form F51-208A-1 and submit it with the F1A application form.

⚠ **If there is more than one applicant/owner, complete this form for each one.**

7) Based on projections, is it conceivable that iA Financial Group could return a **cumulative** amount of $100,000 or more to the **applicant/owner**? Applies to all fund outflows (surrenders, withdrawals and loans), excluding death benefits. ☐ YES ☐ NO

If YES, please complete form F51-208A-1 and submit it with the F1A application form.

⚠ **If there is more than one applicant/owner, complete this form for each one.**

C TO BE COMPLETED FOR APPLICANTS THAT ARE ORGANIZATIONS

I. TAXATION - ALWAYS MANDATORY

8) Is the applicant a corporation or partnership organized in the U.S. or a U.S. state? ☐ YES ☐ NO

If YES, please provide your employer identification number (EIN): _____

9) Does any individual directly or indirectly own or control 25% or more of the organization that will own this policy? ☐ YES ☐ NO

→ If YES, is one of these individuals:
- ☐ A U.S. citizen or a U.S. resident for U.S. tax purposes
- ☐ A tax resident in a jurisdiction other than Canada or the United States
- ☐ Neither of the above

} Please complete form F51-208A-3 and submit it with the F1A application form.

→ If NO, is the senior official of the organization:
- ☐ A U.S. citizen or a U.S. resident for U.S. tax purposes
- ☐ A tax resident in a jurisdiction other than Canada or the United States
- ☐ Neither of the above

} Please complete form F51-208A-3 and submit it with the F1A application form.

II. ANTI-MONEY LAUNDERING - FOR GENESIS, LEGACY AND iA PAR POLICIES ONLY

10) Is the applicant acting on the instructions of an undisclosed individual or organization (a third party)? ☐ YES ☐ NO

A third party includes, but is not limited to, the following:
- a person contributing funds to this contract **who is not the applicant/owner**
- an attorney appointed under a power of attorney
- an undisclosed individual or organization that is instructing the applicant/owner

If YES, the instructions are provided by (provide name): _____

☐ An individual → Date of birth: Y Y Y Y M M D D _____

→ Will a lump-sum payment of $100,000 or more be made on this policy by this third party?

☐ Yes ☐ No → If YES, please complete form F51-208A-1 (in the third party's name) and submit it with the F1A application form.

☐ A corporation → Incorporation number: _____ Place of incorporation: _____

☐ Another type of organization (please specify): _____

Relationship to applicant: _____

Address (not only a P.O. box number): _____

_____

Telephone number: _____

Occupation / Type of business (be specific): _____

11) What is the source of funds used to pay the premiums of this insurance?

☐ Business income ☐ Investments ☐ Loan ☐ Other (provide details): _____

12) What is the type of organization?

☐ Corporation (legal entity or stock company whose members are *shareholders*)

☐ Partnership (trade partnership and partnership whose members are *partners*)

☐ Trust ☐ Not-for-profit organization ☐ Other (be specific): _____

13) Existence of the contracting organization

For corporations, a corporate search will be conducted by iA Financial Group to verify the corporation's existence. For non-corporate organizations, please attach paper copies of documents verifying existence. (E.g.: For a partnership, a partnership agreement or a partnership registration; for a trust, the trust agreement or a document amending the trust.)

14) Please attach copies of documents that explain the ownership, control and structure of the organization and a recent document confirming the organization signatories. A chart should be attached for complex organizations.

15) Verify the identity of the individual(s) conducting the transaction on behalf of the organization. If there is more than one individual, verify the identity of each, up to a maximum of three.

Refer to an authentic and unexpired piece of government-issued **photo** identification. Cannot be a municipal identification document.

1. Name and title/position: _____

Type of identification document: _____ Document number: _____

Expiry date (if applicable): Y Y Y Y M M D D _____ Date identity confirmed: Y Y Y Y M M D D _____

Place of issue: _____

2. Name and title/position: _____

Type of identification document: _____ Document number: _____

Expiry date (if applicable): Y Y Y Y M M D D Date identity confirmed: Y Y Y Y M M D D

Place of issue: _____

3. Name and title/position: _____

Type of identification document: _____ Document number: _____

Expiry date (if applicable): Y Y Y Y M M D D Date identity confirmed: Y Y Y Y M M D D

Place of issue: _____

16) Record the name and address of each individual who owns or controls, directly or indirectly, 25% or more of the shares of the corporation or 25% or more of the non-corporate organization.

If there is no individual who owns or controls, directly or indirectly, 25% or more of the shares of the corporation or 25% or more of the non-corporate organization, please tick this box and continue to question 17: ☐

	Full name	Complete address (not only a P.O. Box)
1	First name: Last name:	
2	First name: Last name:	
3	First name: Last name:	
4	First name: Last name:	

17) Record the names of all directors of the board in the case of a corporation or in the case of any other type of organization that has a board of directors. Please attach a separate sheet of paper if needed.

	Full name		Full name
1	First name: Last name:	**3**	First name: Last name:
2	First name: Last name:	**4**	First name: Last name:

18) In the case of a trust, record the names, dates of birth and addresses of all trustees, all known beneficiaries, and all settlors. Please attach a separate sheet of paper if needed. [Note: A settlor is an individual or organization who established the trust.]

	Full name		Complete address (not only a P.O. Box)
1	First name: Last name: Date of birth: Y Y Y Y M M D D	☐ Trustee ☐ Beneficiary ☐ Settlor	
2	First name: Last name: Date of birth: Y Y Y Y M M D D	☐ Trustee ☐ Beneficiary ☐ Settlor	
3	First name: Last name: Date of birth: Y Y Y Y M M D D	☐ Trustee ☐ Beneficiary ☐ Settlor	
4	First name: Last name: Date of birth: Y Y Y Y M M D D	☐ Trustee ☐ Beneficiary ☐ Settlor	

19) Is the applicant/owner a not-for-profit organization? ☐ YES ☐ NO

If YES, please provide the following information:

– Registered as a charity with the Canada Revenue Agency? ☐ YES ☐ NO

– Canada Revenue Agency registration number: _____

– Does the applicant/owner solicit charitable donations from the public? ☐ YES ☐ NO

This page has intentionally been left blank.

Application no.

REQUESTED COVERAGE

6 GENESIS (Attention – Complete beneficiary section on pages 15 and 16.)

⚠ **Joint insured(s) – Complete the Addition of Coverage form (F3A).**

☐ Individual coverage

☐ Joint coverage ⟶ ☐ First to die ☐ Last to die ☐ Last to die, paid-up on first to die

Portion of accumulation fund payable automatically on death of each insured: ____ %

If no instructions are provided, 100% will be payable.

GENESIS ⚠ For Genesis, provide the current version of the complete illustration signed by the client and the information required under the *Proceeds of Crime (Money Laundering) and Terrorist Financing Act and Regulations* (page 5).

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 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

Supplementary Income Rider (SI) ⟶ Please complete questions 17.B.

Amount of the SI benefit: $ /month

(min. $100, max. $2,000 without exceeding the eligible benefit, section 17.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.)

Automatic Optimization of the Face Amount (AOFA)

☐ Yes ☐ No

If no instruction is given, we will use the AOFA.

Death benefit

☐ Face amount

☐ Face amount + fund

☐ Face amount + fund with wealth maximizer option

- No reduction before ____ years (minimum 5 years)
- Floor face amount $ ____ (minimum $25,000)

If no instructions are given, the wealth maximizer option is not exercised.

Cost of insurance

☐ Annual (YRT)

Levelling of the cost of insurance is planned after ____ years. This is not an automatic option and must be requested by the applicant.

☐ Level only (with no Quick payment option)

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

⚠ **On the applicant ⟶ If other than insured 1, complete the Addition of Coverage form (form F3A).**

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.

GENESIS

INVESTMENT ACCOUNTS

Automatic Investment Instructions (AII) (Maximum 10; if no instructions are provided, we will use the Diversified (iA) account.)
Designated Deduction Account (DDA) (Maximum 10; if no instructions are provided, we will use the Automatic Investment Instructions (AII).)

Guaranteed Interest Accounts

	% AII	% DDA
5-year average		
6-month term		
1-year term		
2-year term*		
3-year term*		
4-year term*		
5-year term*		
10-year term*		

Market Index Accounts

	% AII	% DDA
Money Market		
Bond		
Canadian Stock		
Global Stock		
Global Allocation		
International Stock		
European Stock		
U.S. Stock		
U.S. Stock/DAQ		

Diversified Strategy

	% AII	% DDA
Prudent Account		
Moderate Account		
Balanced Account		
Growth Account		
Aggressive Account		

Active Management Accounts

	% AII	% DDA
Global Diversified (iA)		
Canadian Stock (Fidelity)		
Canadian Stock Small Cap (Fidelity)		
U.S. Dividend Growth (iA)		
European Stock (Fidelity)		
Smoothed Return Diversified Account*		
Global Stock (iA)		
Diversified (iA)		
Global Diversified (Loomis Sayles)		
Dividend Growth (iA)		
Global Dividend (Dynamic)		
Strategic Equity Income (iA)		
NorthStar® (Fidelity)		
Canadian Bond (iA)		
Global Health Care (Renaissance)		

Other

	% AII	% DDA		% AII	% DDA

iA Financial Group reserves the right to reimburse deposits at their market value if the contract is refused by the client.

*The 2 to 10-year term guaranteed interest accounts and the smoothed return diversified account are not available in the shuttle fund. For the shuttle fund, these accounts are replaced by the 1-year guaranteed interest account.

Application no.

REQUESTED COVERAGE

7 LEGACY (Attention – Complete beneficiary section on page 15.)

⚠ **Joint insured(s) – Complete the Addition of Coverage form (F3A).**

☐ Individual coverage

☐ Joint last to die coverage

Portion of accumulation fund payable automatically on death of each insured: ____ %

If no instructions are provided, 100% will be payable.

LEGACY ⚠ **For Legacy, provide the current version of the complete illustration signed by the client and the information required under the *Proceeds of Crime (Money Laundering) and Terrorist Financing Act and Regulations* (page 5).**

Base Coverage

$

Term Life Coverage Rider

T10 R & C $

T20 R & C $

Pick-A-Term T25 $

Pick-A-Term T30 $

BONUS PAYMENT OPTION

☐ Paid-Up Additions (PUA)
* Default choice if no indication is provided

☐ Deposit

PAID-UP ADDITIONS (PUA) ALLOCATION OPTION

☐ No PUA allocation

☐ PUA allocation
Amount: $

☐ **Individual to Joint Last to Die Rider**

⚠ **On the applicant ⟶ If other than insured 1, complete the Addition of Coverage form (form F3A).**

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.

INVESTMENT ACCOUNTS

Automatic Investment Instructions (AII) (Maximum 10; if no instructions are provided, we will use the EquiBuild (iA) Account.)
Designated Deduction Account (DDA) (Maximum 10; if no instructions are provided, we will refer to the terms of the contract.)

Market Index Accounts

	% AII	% DDA
Canadian Stocks		
U.S. Stocks		
U.S. Stocks / DAQ		
European Stocks		
International Stocks		
Global Stocks		
Bonds		

Guaranteed Interest Accounts

	% AII	% DDA
Daily Interest Account		
5-year term*		
10-year term*		

Active Management Index Accounts

	% AII	% DDA
Dividend Growth (iA)		
EquiBuild (iA)*		

Other

	% AII	% DDA

iA Financial Group reserves the right to reimburse deposits at their market value if the contract is refused by the client.

* The 5-year term and 10-year term guaranteed interest accounts as well as the EquiBuild (iA) account are not available in the shuttle fund. For the shuttle fund, these accounts are replaced by the daily interest account.

Application no.

REQUESTED COVERAGE

8 iA PAR (Attention – Complete beneficiary section on pages 15 and 16.)

Version

☐ iA PAR **Estate** ☐ iA PAR **Wealth**

⚠ **Joint insured(s) – Complete the Addition of Coverage form (F3A).**

☐ Individual coverage ☐ Joint last to die coverage

iA PAR ⚠ **For iA PAR, provide the current version of the complete illustration signed by the client and the information required under the *Proceeds of Crime (Money Laundering) and Terrorist Financing Act and Regulations* (page 5).**

Base coverage and premium payment duration

$ _____ Payable to age 100

$ _____ 10-Year Payment

$ _____ 20-Year Payment

DIVIDEND OPTIONS

☐ Paid-Up Additions (PUA)*

- ☐ No contribution to the Additional Deposit Option (ADO)*
- ☐ With annual contribution to the ADO $ _____

(not available for the 10-year Payment coverage)

☐ Annual premium reduction

(available only if the premium payment frequency is annual)

☐ Payable in cash

☐ Deposit with interest

* Default choices if no instructions are provided

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 17.B.1.

Insurance Needs	Benefit Chosen	Benefit Duration
$ _____ /month	$ _____ /month	☐ 2 years ☐ 5 years ☐ To age 65
As per the Needs Analysis	Min. $300, max. $3,500	

⚠ **On the applicant ⟶ If other than insured 1, complete the Addition of Coverage form (form F3A)** ☐ WPDis for life

Application no.

REQUESTED COVERAGE

9 TRADITIONAL INSURANCE (Attention – Complete beneficiary section on pages 15 and 16.)

⚠ **Joint insured(s) and/or additional insured(s) ⟶ Complete the Addition of Coverage form (F3A).**

☐ Individual coverage

☐ Joint coverage ⟶ ☐ First to die ☐ Last to die ☐ Last to die, paid-up on first to die

Whole Life Coverage

L10 $

L20 $

L65 $

L100 $

T100 $

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.

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

Supplementary Income Rider (SI) ⟶ Please complete questions 17.B.

Amount of the SI benefit: $ /month

(min. $100, max. $2,000 without exceeding the eligible benefit, section 17.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.)

10 TRANSITION 25 ILLNESSES (Attention – Complete beneficiary section on page 16.)

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

TRANSITION 25 Illnesses

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 $ ☐ ROPD ☐ FRP 20

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 17.B.

Amount of the SI benefit: $ /month

(min. $100, max. $2,000 without exceeding the eligible benefit, section 17.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 ⟶ If other than insured 1, complete the Addition of Coverage form (form F3A).** ☐ WPDis for life

Application no.

REQUESTED COVERAGE

11 TRANSITION 4 Illnesses (Attention – Complete beneficiary section on page 16.)

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

TRANSITION 4 Illnesses

T10 R & C Level	$	☐ ROPD	T75	$	☐ ROPD	☐ FRP 15 or ☐ FRP 65
T10 R & C Decreasing 50%	$	☐ ROPD	T100	$	☐ ROPD	☐ FRP 15 or ☐ FRP 65
T20 R & C Level	$	☐ ROPD	T100 10-Year Payment	$	☐ ROPD	☐ FRP 20
T20 R & C Decreasing 50%	$	☐ ROPD	T100 20-Year Payment	$	☐ ROPD	☐ FRP 20
T25 R & C Level	$	☐ ROPD				
T25 R & C Decreasing 50%	$	☐ ROPD				

* 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 17.B.

Amount of the SI benefit: $ /month

(min. $100, max. $2,000 without exceeding the eligible benefit, section 17.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 ⟶ If other than insured 1, complete the Addition of Coverage form (form F3A).** ☐ WPDis for life

12 ADDITIONAL BENEFITS

On the applicant ⟶ If other than insured 1, complete the Addition of Coverage form (form F3A).

☐ 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)	$	☐ Paramedical care	
☐ Accidental death and dismemberment (AD&D)	$	☐ Hospitalization	$
☐ Guaranteed insurability (GI)	$	☐ Hospitalization and home care	$

CHILD MODULE

⚠ **For each child, complete the Addition of Coverage form F3A.**
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 $

13 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) | Sex ☐ M ☐ F | ☐ Revocable ☐ Irrevocable

Date of birth Y Y Y Y M M D D | % | Relationship to proposed insured

Contingent beneficiary 2 (last name, first name) | Sex ☐ M ☐ F | ☐ Revocable ☐ Irrevocable

Date of birth Y Y Y Y M M D D | % | 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) | Sex ☐ M ☐ F | ☐ Revocable ☐ Irrevocable

Date of birth Y Y Y Y M M D D | % | Relationship to proposed insured

Contingent beneficiary 2 (last name, first name) | Sex ☐ M ☐ F | ☐ Revocable ☐ Irrevocable

Date of birth Y Y Y Y M M D D | % | 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) | Sex ☐ M ☐ F | ☐ Revocable ☐ Irrevocable

Date of birth Y Y Y Y M M D D | % | Relationship to proposed insured

Contingent beneficiary 2 (last name, first name) | Sex ☐ M ☐ F | ☐ Revocable ☐ Irrevocable

Date of birth Y Y Y Y M M D D | % | Relationship to proposed insured

BENEFICIARY OF THE FUNDS – GENESIS AND LEGACY POLICIES

The lack of designation constitutes a revocable designation in favour of the beneficiary or beneficiaries named in the "Beneficiary – Life Insurance" section above.

☐ Applicant(s) - in equal parts if applicable **OR** ☐ Beneficiary of insured **no. 1 OR**

Beneficiary

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) | Sex ☐ M ☐ F | ☐ Revocable ☐ Irrevocable

Date of birth Y Y Y Y M M D D | % | Relationship to proposed insured

Contingent beneficiary 2 (last name, first name) | Sex ☐ M ☐ F | ☐ Revocable ☐ Irrevocable

Date of birth Y Y Y Y M M D D | % | Relationship to proposed insured

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

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

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

2. Return of premiums upon 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 _____

14 BILLING

Current premium

$

Target premium (Genesis and Legacy)

$

Or: ☐ Minimum premium (Legacy)
☐ Reference premium (Genesis)

Premium payment frequency

☐ MONTHLY (Attach a void cheque and complete section 24.)

☐ ANNUAL

Payment of the first premium

If no option is selected and there is no amendment in the contract, billing will begin 15 days after the contract has been issued.

☐ By cheque $

This amount will be deducted from the first premium or will be refunded if the contract is not issued.

Attach a cheque payable to iA Financial Group. Post-dated cheques and money orders from Canada Post are not accepted.

☐ By pre-authorized debit (PAD)

$

This amount will be deducted from the first premium or will be refunded if the contract is not issued.

Attach a void cheque to section 24. A withdrawal will automatically be made from the client's bank account within **three business days** of entry of the application in our administrative systems.

Do not enclose a cheque.

☐ Cash on delivery (COD)

Attach a void cheque to section 24. No bank withdrawal will be made during the assessment of the application.

Upon delivery of the contract, the client will be required to pay all premiums due since the effective date of the contract.

An amendment must be signed upon delivery of the contract.

No deposit will be accepted.

15 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.**

16 AGENT

Service agent

Last and first name | Active code | SU | %

Agency | Code

Work phone no. | Extension | Cell phone no.

Email

Last and first name | Active code | SU | %

Agency | Code

Work phone no. | Extension | Cell phone no.

Email

Agent policy

Please specify the relationship:

☐ Agent
☐ Spouse
☐ Child

This page has intentionally been left blank.

Application no.

17 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
- ☐ Refugee protection claimant
- ☐ Study permit
- ☐ Work permit
- ☐ Convention refugees
- ☐ Canadian citizen
- ☐ Under Live-In Caregiver Program
- ☐ Other: _____

3) Education, occupation, income and net worth

A. Highest level of education completed:
- ☐ No diploma
- ☐ High school or equivalent
- ☐ Apprenticeship Program
- ☐ College
- ☐ Undergraduate Certificate
- ☐ Bachelor's Degree
- ☐ Postgraduate Degree

B. Occupation

Employment:_____

Employer (name of the business): _____

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:
- ☐ I am an employee

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: _____

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.**

18 REQUIREMENTS

Life insurance applications from $2,000,001 to $5,000,000 for ages 15 to 50, OR from $300,001 to $1,000,000 for ages 51 to 60

1. Choice of Declaration of Insurability

   Among the following three (3) options, how would you like to complete the declaration of insurability?

   ☐ Complete the declaration of insurability and benefit from the decision at the point of sale.

   ☐ Order a phone interview and the decision will be sent to me later, following review of the file (*complete the Requirements to order section below*).

   ☐ Order a paramedical examination and a blood profile. The decision will be sent to me later, following review of the file (*complete the Requirements to order section below*).

2. TERM life coverage from $2,000,001 to $5,000,000

   Would you like to check whether you can benefit from our preferential rates subject to additional requirements? ☐ YES ☐ NO

   If yes, vital signs and blood profile must be added in Requirements to order for choices: Declaration of insurability or Phone interview.

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 section if the declarations of insurability are not required.*

1. Indicate the requirement: ☐ Phone interview ☐ Vital signs ☐ Blood profile ☐ Paramedical examination

2. Service provider: _____ Authorization number: _____

3. Who will order the requirements listed above?

   ☐ Advisor/Associate ☐ MGA/Agency ☐ iA Financial Group (Please provide the following information.)

   In which language would you like to have the service provided? ☐ English ☐ French ☐ Other: _____

   What is the client's contact number to arrange an appointment? | | | | | | | | | | |

   When is the best time to contact the client? ☐ Weekday ☐ Weekend / ☐ Morning ☐ Afternoon ☐ Evening

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

5. If the amount of insurance is over $10,000,000, 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 20 F and 20 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

19 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:

_____

_____

_____

Application no.

20 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
☐ Amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease)
☐ Polycystic kidney disease**
☐ Death from an unknown cause
☐ Cardiovascular or cerebrovascular disease (e.g.: stroke, CVD, TIA)
☐ Parkinson's disease
☐ Neurological disease** (excluding epilepsy)
☐ Hemophilia**
☐ Diabetes
☐ Alzheimer's disease
☐ Huntington's chorea**
☐ Any other hereditary disorder** (specify): ____________________
☐ I don't know since I was adopted or I have no contact with my family

Relationship	Please specify disease (E.g.: type of cancer*, type of diabetes, etc.)	Approximate age at diagnosis

* If you have disclosed a family history of **breast cancer** or **colon cancer,** answer **question 1 in section 21 A.**
** Please answer **question 2 in section 21 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 **21 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 **21 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 **21 N**.) ☐ NO

* **Please also provide answers to the questions in section 21 related to these conditions (e.g.: asthma) or the questions in section 21 O (Medical general questionnaire), if applicable.** If needed, refer to the medical conditions and questionnaires table attached to this application.

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 21 (e.g.: section 21 G for asthma, 21 E for HBP, etc.; or section 21 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 21 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 21 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 yes, please list all disorders and answer the questions as indicated.

1. Musculoskeletal disorder	2. Have you had any relapses in the past two (2) years or is it still currently present?	3. Have you fully recovered from this disorder for at least 12 months?
	☐ YES → Questions in section **21 B** or **21 C** ☐ NO (Go to question 3.)	☐ YES ☐ NO → Questions in section **21 B** or **21 C**
	☐ YES → Questions in section **21 B** or **21 C** ☐ NO (Go to question 3.)	☐ YES ☐ NO → Questions in section **21 B** or **21 C**
	☐ YES → Questions in section **21 B** or **21 C** ☐ NO (Go to question 3.)	☐ YES ☐ NO → Questions in section **21 B** or **21 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 21 O**
- ☐ Any heart or blood vessel disorder → **section 21 O**
- ☐ Any type diabetes or glucose intolerance → **section 21 I**
- ☐ Asthma and currently a smoker → **section 21 G**
- ☐ Bariatric surgery → **section 21 O**
- ☐ Cancer → **section 21 O**
- ☐ Cerebrovascular accident (stroke) → **section 21 O**
- ☐ Crohn's disease/ Ulcerative colitis → **section 21 O**
- ☐ Deafness → **section 21 O**
- ☐ Familial muscular disease (muscular dystrophy) → **section 21 O**
- ☐ Hepatitis B or C → **section 21 O**
- ☐ Hereditary disease → **section 21 O**
- ☐ Herniated disc → **section 21 B**
- ☐ HIV/AIDS → **section 21 O**
- ☐ Malformation(s) and/or congenital diseases → **section 21 O**
- ☐ Sleep apnea → **section 21 M**
- ☐ Temporary loss of vision or blindness → **section 21 O**
- ☐ Transient ischemic attack (TIA) → **section 21 O**
- ☐ Tumor, cyst, nodule, mass, fibroma or polyp → **section 21 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 21 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 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 21 S.

2) **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 21 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 21 S.)

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 21 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 21 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 21 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 21 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 21 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 21 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 21 P.**

☐ Drug use → **Please answer the questions in section 21 Q.**

H Physicians and attending physician's statements

1) Do you have a family doctor or a regular health care facility? ☐ YES ☐ NO

If yes, please indicate the name and full address:

_____

_____

What was the date of your last consultation? Y Y Y Y M M

2) Does your family doctor or regular health care facility possess medical information pertaining to the declared conditions? ☐ YES ☐ NO

If not, please indicate the physician and/or the health care facility holding the medical information for each of these conditions:

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

21 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)	☐	☐	☐
– Thoracic region (middle of the back)	☐	☐	☐
– Lumbosacral region (lower back, including sciatic nerve)	☐	☐	☐
– Other, specify:	_____	_____	_____
Please identify in the list below the type of treatment received or to come:			
– Injection	☐	☐	☐
– Anti-inflammatory or muscle relaxant drugs	☐	☐	☐
– Medication derived from morphine, opiate or marijuana/cannabis*	☐	☐	☐
– Medication derived from methadone*	☐	☐	☐
– 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.):	_____ _____ _____	_____ _____ _____	_____ _____ _____

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 provide the location of pain or discomfort including the side of the body (e.g.: left shoulder, right elbow, both hips, etc.):			
Please identify in the list below the type of treatment received or to come:			
– Injection	☐	☐	☐
– Anti-inflammatory or muscle relaxant drugs	☐	☐	☐
– Medication derived from morphine, opiate or marijuana/cannabis*	☐	☐	☐
– Medication derived from methadone*	☐	☐	☐
– 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.):			
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:			

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, what is the date of your last medication treatment?	☐ YES ☐ NO Y Y Y Y M M	☐ YES ☐ NO Y Y Y Y M M	☐ YES ☐ NO Y Y Y Y M M
Have you ever been hospitalized or had inpatient therapy for this condition?	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
If yes, please provide more information about your hospitalization or therapy (dates, treatments, complications,follow-ups, exams, etc.):			

E **High blood pressure** (Examples: HBP, hypertension, high blood pressure, elevated blood pressure, etc.)

1) Is your condition well controlled with no complication according to your physician?

☐ YES

☐ NO ⟶ Please provide more information regarding the complications of your condition (types of complications, dates, exams, treatments, follow-ups, etc.):

_____

_____

_____

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?
   ☐ Diet ☐ Oral medication ☐ Insulin ☐ None

If you answered "Gestational diabetes (prior history)":

4) Are you currently pregnant?
   ☐ YES → Are you currently more than 24 weeks pregnant? ☐ YES ☐ NO
   ☐ NO → Has a licensed medical professional pronounced you fully recovered from this condition? ☐ YES ☐ NO

J **Gastroesophageal reflux** (Examples: Dyspepsia, heartburn, stomach acidity, esophageal reflux, reflux esophagitis, etc.)

1) Please identify the severity of your symptoms:
   - ☐ Mild symptoms, no interference with activities of daily living, no medication.
   - ☐ Moderate symptoms, some interference with activities of daily living, under medication.
   - ☐ Severe symptoms, significant interference with activities of daily living.
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 answered "Moderate" or "Severe", please provide details concerning your condition (symptoms, time off work or off school, employment or educational path, etc.):

_____

_____

L **Migraine and headache** (Examples: Tension headaches, migraine, etc.)

1) Which of the following best describes your headaches?

☐ (a) Increasing in frequency and/or recent onset and still under investigation

☐ (b) Mild/occasional with the use of over the counter medication or no medication

☐ (c) Moderate with the use of over the counter medication and/or occasional use of prescription medication

☐ (d) Severe, persistent, resistant to medication

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

_____

_____

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.):

_____

_____

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:

_____

_____

_____

---

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:

_____

_____

_____

NON-MEDICAL QUESTIONNAIRES

P Alcohol

To be completed if you answered YES to question 20.G.4 or 20.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

Cannabis (marijuana, hashish, etc.) ⟶ To be completed if you answered YES to question 20.G.5, 20.G.6 or 20.G.7 (drug use).

Have you ever used cannabis (marijuana, hashish, etc.)?

☐ NO

☐ YES ⟶ Do you currently use cannabis (marijuana, hashish, etc.) or did you do so in the last year?

☐ NO ⟶ When was the last time you used it? Y Y Y Y M M

Please provide the average quantity and frequency of your cannabis (marijuana, hashish, etc.) use before quitting:

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

☐ YES ⟶ Please provide the average quantity and frequency of your current cannabis (marijuana, hashish, etc.) use:

Consumption: _____ per _____ (day/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

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 20.G.1 (driver's licence suspended), please answer the questions in sections 1 and 2 below.

If you answered Yes to question 20.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?

☐ NO ☐ YES → Please provide the date when your licence was reinstated: Y Y Y Y M M

3) Did you drive while your licence was suspended (excluding driving with a restricted licence or with a vehicle equipped with an alcohol ignition interlock device)? ☐ YES ☐ NO

S Non-medical general questionnaire

If you answered YES to the questions on "foreign travels" (20.F.1), "sports and aviation" (20.F.2) or "criminal record" (20.G.3), please provide all relevant information as listed below:

- **For foreign travels:** Countries you will visit, date of departure, duration, reasons for stay, etc.
- **For sports and aviation:** Beginning and end date, locations, type and characteristics (be as precise as possible), accidents or injuries experienced, frequency, etc.
- **For criminal record:** Nature of the criminal act, date, type of conviction, probation (start and end date), etc.

Please provide details here:

_____

_____

_____

_____

Application no.

22 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.

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 disability claim and obtain the required documentation.

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.

We acknowledge having read the interim insurance agreement in case of death or critical illness, when offered, and having understood the terms thereof.

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 delivered as soon as it is available on My Client Space and that documents that are currently only available in paper format will continue to be sent via regular mail. A copy of any document could always be sent to us by regular mail upon request.

REGULATORY QUESTIONS – APPLICANTS' CONFIRMATION AND AUTHORIZATION

We confirm that the information provided in the section "Regulatory questions" is accurate and complete. If we are acting on behalf of an organization, we also confirm that we have been duly authorized to sign on behalf of such organization and that the documents provided are accurate, current and complete. We agree to immediately notify iA Financial Group of any errors, omissions or changes in the information provided in this form. This includes any changes to an entity's CRS/FATCA classification and any change in residency status or any change in U.S. citizenship status of any individual who owns or controls, directly or indirectly, 25% or more of an organization that will own this contract. We authorize the use of a credit check or identification product to verify our identity when required.

FOR QUEBEC RESIDENTS ONLY – AMENDMENTS TO THE *CHARTER OF THE FRENCH LANGUAGE*

We confirm that we have received the French version of the contract before its signature in English. We request that the contract herein and any other related documentation be drawn up in English.

We agree that a photocopy of this authorization is as valid as the original.

Signed at	Province	this	day of	20

Proposed insured (if aged 16 years or older)	**Legal guardian or parent (if insured is not authorized to sign)**	**Witness (if applicable)**
Last and first name (write legibly)	Last and first name (write legibly)	Last and first name (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.**

Applicant(s) for personal insurance OR Authorized signatory(ies) if applicant is a company

Last and first name (write legibly)	Last and first name (write legibly)
Signature	Signature
X	X

Agent

By signing below, the agent confirms that he has provided a disclosure statement to the applicant which discloses the company or companies he represents and his relationship with them; that he receives compensation (such as commissions) for the sale of insurance products and may receive other compensation such as bonuses, invitations to conferences or other incentives; and all financial interests that he may have with respect to this transaction. The agent confirms as well that he is not the person paying the associated premiums for this transaction, unless it concerns himself, his spouse and/or his children. The agent also declares that he has all the necessary licences, certificates and knowledge (see ia.ca/products-advisors) to submit this application and provide customer service.

Proceeds of Crime (Money Laundering) and Terrorist Financing Act and Regulations – Agent's Confirmation

If this is an application for Genesis, Legacy or iA PAR insurance, I, the agent, confirm that:

- For each applicant that is an individual, I met with them and I verified their identity by reviewing their authentic, unexpired, government-issued photo identification document;
- For each applicant that is an organization, I met with the individual(s) conducting the transaction and I verified their identity by reviewing their authentic, unexpired, government-issued photo identification document;
- I have taken reasonable measures to determine if the applicant is acting on behalf of a third party;
- If there is a lump-sum payment of $100,000 or more or if, based on projections, a cumulative amount of $100,000 or more could be paid to the applicant/owner of the contract, I have taken reasonable measures to determine if the applicant/owner or the payer, or a family member or a close associate of either, is a politically exposed foreign person, a politically exposed domestic person or the head of an international organization; and
- For a politically exposed foreign person, a politically exposed domestic person or the head of an international organization, I have taken reasonable measures to establish the source of their wealth.

If you have reasonable grounds to suspect an undisclosed third party is involved in this transaction, please email details to **infolife@ia.ca**.

FOR QUEBEC RESIDENTS ONLY – AMENDMENTS TO THE *CHARTER OF THE FRENCH LANGUAGE*

I confirm that I have provided my clients, who live in Quebec, with a copy of the contract in French before its signature in English.

Agent

X

This page has intentionally been left blank.

23 AUTHORIZATION RELATING TO THE PROTECTION OF PERSONAL INFORMATION

I authorize iA Financial Group, its affiliates and its reinsurers to collect from any health care professional, public or private health or social services facility, the Régie de l'assurance maladie du Québec, any insurance company, financial institution, employer, former employer, MIB LLC or private or public organization which holds personal or medical information about me, or to disclose information about me to them including my health status, medical history and any other information relevant for processing requests related to my contract.

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) | Witness | Legal guardian or parent (if insured is not authorized to sign)

X | X | X

I authorize iA Financial Group, its affiliates and its reinsurers to collect from any health care professional, public or private health or social services facility, the Régie de l'assurance maladie du Québec, any insurance company, financial institution, employer, former employer, MIB LLC or private or public organization which holds personal or medical information about me, or to disclose information about me to them including my health status, medical history and any other information relevant for processing requests related to my contract.

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) | Witness | Legal guardian or parent (if insured is not authorized to sign)

X | X | X

The consent forms below must be completed and signed by proposed insureds that reside or have resided in Alberta only.

iA Financial Group ia.ca

INSURED 1

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

X _____ | _____

Client or authorized representative's name | Witness' signature | Witness' name

_____ | X _____ | _____

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

X _____ | _____

Client or authorized representative's name | Witness' signature | Witness' name

_____ | X _____ | _____

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

This page has intentionally been left blank.

iA Financial Group ia.ca

Application no.

24 PRE-AUTHORIZED DEBIT (PAD) AGREEMENT

In this Pre-Authorized Debit Agreement (the "PAD Agreement"), "I" refers to each account holder, who declares the following with respect to himself or herself:

- I authorize iA Financial Group and the financial institution designated (or any other financial institution I may authorize at any time) to begin deductions from the account specified for regular recurring payments and recurring payments on a sporadic basis, if applicable, for the payment of all premiums, deposits, instalments and charges arising from the Contract.
- Regular payments will be debited based on the date and the frequency I have chosen, whereas recurring payments on a sporadic basis can be debited on any date, in accordance with the banking information provided. iA Financial Group will make sure to obtain my authorization before debiting a recurring sporadic payment from my account.
- I agree that, for the purpose of the PAD Agreement, all PADs from my account will be treated as Personal unless I advise otherwise.
- **I waive the right to receive pre-notification of an increase or decrease in the amount to be debited or a change in the date and/or frequency of these payments.**
- I agree that iA Financial Group is not required to provide me with written notice of a change in a PAD amount that is made as a result of my request.
- If a PAD is dishonoured for any reason such as, but not limited to, insufficient funds (NSF), stop payment or account closed, iA Financial Group is authorized to resubmit the payment. **Any charges incurred by iA Financial Group as a result of a dishonoured PAD will be added to the subsequent PAD.**
- I may cancel or modify the PAD Agreement at any time, subject to providing iA Financial Group thirty (30) days notice in writing. To obtain a sample cancellation form or for more information on my right to cancel the PAD Agreement, I may contact my financial institution or visit www.payments.ca regarding Rule H1 – Pre-Authorized Debits (PADs).
- Any cancellation of the PAD Agreement will not affect my insurance contract(s) and/or contract(s) for financial services, so long as payment is provided, as required, by an alternate method that is acceptable to iA Financial Group.
- **If iA Financial Group assigns this PAD Agreement, it will provide written notice to me of the assignment prior to any amount being deducted in the assignee's name.**
- I have certain recourse rights if any PAD does not comply with the PAD Agreement. For example, I have the right to receive reimbursement for any PAD that is not authorized or is not consistent with the PAD Agreement. To obtain more information on my recourse rights, I should contact my financial institution or visit www.payments.ca regarding Rule H1 – Pre-Authorized Debits (PADs).
- Before iA Financial Group debits the first PAD payment, it must receive all required documents, duly completed, and be allowed a reasonable period of time to complete its administrative processes.
- I confirm that I have authority under the terms of my account agreement to authorize this debit. I also confirm that all persons whose signatures are required to authorize transactions within the account have signed the PAD Agreement.
- If any of the details contained in this PAD Agreement are incorrect, I will contact iA Financial Group immediately at the contact information provided.

GENERAL INFORMATION

1. Do you already pay by PAD?

☐ No ⟶ **(Complete items 3 and 4 and sign.)** ☐ Yes ⟶ **(Complete items 2 and 4 and sign.)**

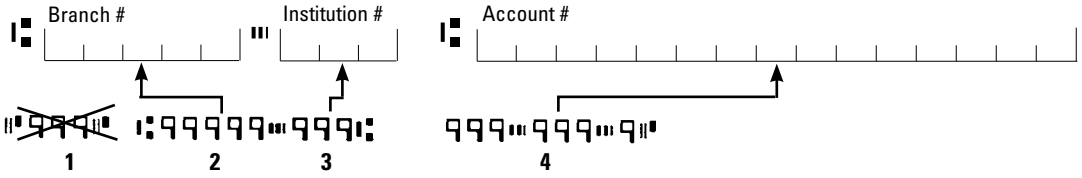
2. The premiums must be withdrawn from the same bank account as the one used for the following insurance policy: _____

⚠ The authorized signatory(ies) must always be the same as the one(s) that authorized the original transaction for which the authorization number had been issued.

3. Banking Information – Attach a personalized void cheque; if a void cheque is not attached, please complete all the banking information below.

Name of financial institution: _____

Name of account holder(s): _____



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.

GENERAL INFORMATION (Continued)

4. PAD Agreement: Variable

PAD category: ☐ Personal ☐ Business (If both boxes are left unchecked, the PAD category will be considered "Personal".)
↳ A business PAD means a PAD for the payment of goods or services related to a business or commercial activity of the payor.

Day of withdrawal (The selected day applies to subsequent withdrawals after the policy has been placed. The details for the initial withdrawal may be different and will be contained in the Confirmation of issue.)

☐ Day chosen by the client: _____ (1 to 28)

☐ Issue day (**Recommended,** in order to avoid two close withdrawals in the client's bank account.)

The signature of the account holder(s) and/or the policyowner(s) is required.

⚠ → For a joint account, all required signatories must sign this PAD Agreement.
→ For a business, the PAD Agreement must be signed by an authorized signatory (or authorized signatories, if more than one is required). Please attach a copy of the company's resolution designating the authorized signatories.

By signing below, I, the account holder, confirm that I have read, understand, and agree to the terms and conditions of this PAD Agreement. For a joint account I confirm all required signatories have signed this PAD Agreement.

Date: Y Y Y Y M M D D | **X** Account holder's signature | **X** Other account holder's signature, if applicable

I confirm that I have all the necessary authorizations from the bank account holder (if other than myself) in order to allow iA Financial Group to withdraw the premiums from the bank account.

Date: Y Y Y Y M M D D | **X** Policyowner's signature | **X** Other policyowner's signature, if applicable

Service Centre contact information:

Quebec: Industrial Alliance Insurance and Financial Services Inc., Policyowner Services
1080 Grande Allée West, PO Box 1907, Station Terminus, Quebec City, QC G1K 7M3
Telephone: 1-844-442-4636, fax: 1-866-572-1075, email: infolife@ia.ca

Toronto: Industrial Alliance Insurance and Financial Services Inc., Toronto Service Centre, Policyowner Services
26 Wellington Street East, Suite 600, Toronto, ON M5E 1S2
Telephone: 1-844-442-4636, fax: 1-877-780-7231, email: infolife@ia.ca

Vancouver: Industrial Alliance Insurance and Financial Services Inc., Vancouver Service Centre, Policyowner Services
988 W. Broadway, Suite 400, PO Box 5900, Vancouver, BC V6B 5H6
Telephone: 1-844-442-4636, fax: 1-844-739-0634, email: infolife@ia.ca

iA Financial Group ia.ca

Application no.

Give to applicant if deposit made

25 INTERIM INSURANCE AGREEMENT IN CASE OF DEATH, CRITICAL ILLNESS OR ACCIDENTAL FRACTURE (Not applicable to individuals aged under 15 days or over 71 years.)

The interim insurance coverage applies to each proposed insured whose name appears on the application bearing the same number as this agreement, according to the conditions hereunder.

Industrial Alliance Insurance and Financial Services Inc. ("iA Financial Group") offers insurance coverage as of the date the application bearing the same number as this agreement is signed, when an amount equal to 1/12 of the annual premium is paid with the application, including any payment made by enrolling in the PAD mode. The amount will be applied to pay for the policy on the policy issue date.

MAXIMUM AMOUNT OF INSURANCE

The maximum coverage for all **interim** insurance coverages in-force for all applications signed with iA Financial Group for the same proposed insured is $500,000 including accidental death coverage.

POLICY REPLACEMENT

If the requested insurance replaces a contract of iA Financial Group whose face amount is lower than the face amount of the requested insurance, the amount of the interim insurance is the difference between the requested face amount on the application and the face amount of the replaced contract.

If the requested insurance replaces a contract of iA Financial Group whose face amount is greater than or equal to the face amount of the requested insurance, no amount is payable under this interim insurance agreement.

CONDITIONS AND SPECIFIC EXCLUSIONS

This agreement does not include disability, hospitalization or paramedical care coverages and changes of insurability that occur before the date the application is accepted other than if death has occurred or a critical illness has been diagnosed.

Life insurance, accidental death, accidental fracture and critical illness coverages requested on the application are payable according to the terms and exclusions of the underwritten policy and the conditions and exclusions hereunder.

The Interim insurance is null and void if any of the following cases apply:

- If, at the time the application is signed, the proposed insured had consulted or been treated for the illness which caused directly or indirectly his/her death or which led to the diagnosis of a critical illness;
- If, at the time the application is signed, the proposed insured has symptoms for which he/she had not yet consulted a physician or has been advised to undergo treatment or tests that are still pending;
- If the proposed insured had consulted a physician in the 30-day period before the application was signed for a reason other than pregnancy;
- If any answer given on the application, the medical examination report or any other document or process to collect information with regards to the risk is incomplete or false and if a true answer had been given, the application would not have been accepted as requested;
- If the proposed insured is less than 15 days old or more than 71 years old on the nearest birthday when the application is signed;
- If the proposed insured self-inflicts or suffers injuries, commits suicide, dies or suffers an accidental fracture:
  - While committing or attempting to commit a criminal act or hybrid offence;
  - After using drugs or medication other than prescribed by a physician;
  - While he/she is driving a vehicle with a blood alcohol level higher than 80 milligrams per 100 millilitres of blood;
- **Specifically for life insurance, accidental death and accidental fracture coverages**, if the proposed insured, whether sane or insane, commits suicide, attempts suicide or deliberately harms himself or herself.
- **Specifically for the critical illness coverage**, if the proposed insured has already suffered from a covered critical illness or if the diagnosis of a critical illness is cancer or if he/she self-inflicts or suffers injuries or he/she does not survive 30 days after the date of the diagnosis.

TERMINATION OF THE INTERIM INSURANCE AGREEMENT

The interim insurance agreement terminates on the date that the first of the following events occurs:

- The application is accepted without modification;
- 60 days after the application has been accepted with a modification such as a change of class, an extra premium, a rate change or a change in the insurance amount;
- The acceptance by the applicant of a policy issued with a modification;
- The application is denied or cancelled by iA Financial Group, regardless of whether or not the applicant has been advised;
- The cancellation of the application by the applicant;
- In all cases, even though the 60-day period mentioned above has not expired, 90 days after the date the application was signed.

The death benefit and critical illness benefit are payable according to the designations made on the application and the accidental fracture benefit is payable to the applicant.

Signed at | this | day of | 20

Agent

X

Give to insured

26 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 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.

This page has intentionally been left blank.

27 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 • Esophageal reflux • Heartburn	• Reflux esophagitis • Stomach acidity • Stomach pain, etc.	**J- Gastroesophageal reflux**
• ADHD • Attention deficit disorder • Attention deficit hyperactivity disorder	• Concentration disorders • Hyperactivity, etc.	**K- Attention deficit disorder**
• Headache • Migraine	• Tension headaches, etc.	**L- Migraine and headache**
• Apnea/Hypopnea Syndrome • Obstructive sleep apnea	• Obstructive sleep apnea syndrome • Sleep apnea, etc.	**M- Sleep Apnea**
• Biopsy • Colonoscopy/coloscopy • Colposcopy • Echography/Ultrasound (U/S): abdominal, cardiac, breast, pelvic, etc. • Electrocardiogram (ECG/EKG)	• Magnetic resonance Imaging (MRI) • Mammography • Scanner (Pet scan) • Scintigraphy • Stress electrocardiogram (Stress ECG/EKG) • X-ray, etc.	**N- Diagnostic tests or exams**
• 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**

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**

This page has intentionally been left blank.

iA Financial Group ia.ca

28 REFERRALS

Referrals from the file of

Do you have an RRSP? ☐ No ☐ Yes Maturity date Y Y Y Y M M D D

Do you have mortgage insurance? ☐ No ☐ Yes Renewal date Y Y Y Y M M D D

1 Last and first name | Age | Employer

Spouse's last and first name | Age | Children's first names

Address | Telephone

2 Last and first name | Age | Employer

Spouse's last and first name | Age | Children's first names

Address | Telephone

3 Last and first name | Age | Employer

Spouse's last and first name | Age | Children's first names

Address | Telephone

4 Last and first name | Age | Employer

Spouse's last and first name | Age | Children's first names

Address | Telephone

PRIVACY NOTICE

1. Your personal information is precious

We, iA Financial Group and its affiliates[1], are doing everything we can to protect the personal information you entrust to us. That is why we are committed to continually reassessing our practices, keeping them up to date and in line with the high standards regarding your privacy and management of your personal information.

2. What we are doing to protect your personal information

First and foremost, what constitutes personal information? It is information that concerns you and can be used to identify you, directly or indirectly.

2.1 We operate on the basis of 4 important principles

The following principles govern how we ensure your privacy:

- **Ensure secure management.** We implement good management and safeguard practices to secure your personal information and oversee its use.
- **Respect your rights.** You have rights related to the personal information we hold about you. You may exercise them at any time.
- **Be transparent.** We provide you with all relevant information about our privacy practices.
- **Act responsibly.** Our employees, suppliers and representatives (including our financial services advisors) must comply with our privacy practices. Our Chief Privacy Officer ensures that they do and that our practices are always up to date.

2.2 We only collect personal information that is necessary

From whom do we collect your personal information

We collect your personal information primarily from you. We may also collect it from others, depending on the circumstances and the products or services you have with us. For example:

- Your employer
- Public bodies
- Our representatives
- Personal references
- Credit bureaus and reporting agencies
- Other insurers, reinsurers or financial institutions
- Public and private insurance, fraud and claims databases
- Partners who distribute our products and services, such as independent brokers, specialized insurance coverage providers, travel agencies or car dealerships

A person who has or wishes to obtain a product or service from us may also disclose your personal information to us so that you can benefit from that product or service. For example, this person could add you as an insured person.

1 iA Financial Group is primarily composed of the following entities: iA Financial Corporation Inc., Industrial Alliance, Insurance and Financial Services Inc., Industrial Alliance Pacific General Insurance Corporation, Industrial Alliance Auto and Home Insurance Inc., Industrial Alliance Trust Inc., PPI Management Inc., Michel Rhéaume et Associés ltée (MRA), iA Advantages Damage Insurance Inc., SurexDirect.com Ltd., Prysm General Insurance Inc., iA Auto Finance Inc., iA Clarington Investments Inc., Industrial Alliance Investment Management Inc., iA Global Asset Management Inc., iA Private Wealth Inc., Investia Financial Services Inc., IA American Life Insurance Company, American-Amicable Life Insurance Company of Texas, iA American Warranty Corp., Dealers Assurance Company, iA American Warranty, L.P., WGI Service Plan Division Inc., WGI Manufacturing Inc., Lubrico Warranty Inc., National Warranties MRWV Limited, SAL Marketing Inc. The updated list is available on our website at the following address: ia.ca/about-us/group-of-companies.

How do we collect your personal information

We may collect your personal information in a number of ways, including:

- By phone
- In person
- Via our paper and online forms
- Via cookies, when you visit our websites

What personal information do we collect

We only collect the personal information necessary to fulfill the purposes outlined in this notice.

Here are some examples of personal information we may collect:

Categories	Examples
Identification information	Name, date of birth, mailing address, email, phone number, marital status, government identifiers (passport number, driver's licence number, etc.), social insurance number, citizenship, country of birth
Financial information	Income, salary, financial report, investments, information on financial products you have with us or elsewhere, investor profile, rent, mortgage, bank account, credit history and score
Health information	Medical records, medical information related to your claims, paramedical test results, medical history
Insurance information	Information on insurance policies you have with us or elsewhere, claims history, gender at birth, lifestyle habits, criminal record
Employment information	Employment status, current employer, former employers
Information about your assets	Vehicle, residence, recreational vehicle
Information about your family	Name, age, financial situation and health status of your spouse, children or parents

We may also create or infer information from the personal information we collect. For example, we may create a client profile or identifier for you. This information is considered personal information. We manage and protect it in accordance with the same practices as the rest of your personal information.

2.3 We collect your personal information for specific purposes

We collect, use, disclose and retain your personal information solely for the purposes outlined in this notice. We will inform you of the intended purposes at or prior to the time we collect your personal information.

The following purposes may be essential to our relationship with you, depending on the products and services you request:

Categories	Specific purposes
Know who you are	– Verify your identity – Keep your contact information up to date – Recognize you through iA Financial Group – Verify that your personal information is accurate

Categories	Specific purposes
Build a relationship with you	– Contact you if you request it and answer your questions – Understand your needs and your profile to advise you – Analyze your requests for products or services – Determine whether you are eligible for a product or service, and if it is right for you – Determine the cost of a product or service you request
Maintain our relationship with you	– Day-to-day administration of your contracts, for example, amending them or informing you of changes in your investments – Process your payments – Process your insurance claim, transaction or any other contract-related requests – Handle any complaints or dissatisfaction – Transfer your contracts to or from another financial institution – Transfer your file to another representative, if necessary
Comply with laws and manage risk	– Detect, prevent and contain fraud and unauthorized or illegal activities, such as money laundering and cyber threats – Monitor business practices to ensure that they are sound – Verify transactions – Adequately train our employees and representatives – Comply with our legal obligations and the requirements of courts, regulatory authorities or self-regulatory organizations – Have certain risks insured by another insurer (reinsurance)

Some purposes are optional for doing business with us. You can consent to them to benefit from a distinctive client experience and to obtain offers tailored to your needs.

We must obtain your consent to collect, use, disclose and retain your personal information for the following purposes:

Categories	Specific purposes
Improve our products and services and provide a distinctive client experience	– Acknowledge your differences and similarities with respect to our other clients – Understand how our digital tools and websites are used in order to improve them – Consult with you to gain more insight into your experience, reactions and interactions with us – Keep up with the various stages of your life to make our products and services even more useful and effective over the course of our relationship with you – Allow all our clients to benefit from the lessons gleaned from you as we work to improve our client experience – Make it easier for you to enter your information when requesting a product or service (e.g., automatically fill in certain fields)
Keep you informed of our promotions, products, services, contests and events that may be of interest to you	– Understand the product and services portfolio you have with iA Financial Group in order to offer you relevant products and services that are adapted to your reality – Contact you at the right time, in the right way – Offer you benefits or advantageous pricing based on the products or services you have with iA Financial Group – Keep you informed of contests or other promotional events that may be of interest to you

2.4 We may share your personal information with other individuals or organizations

To whom may we disclose your personal information

In order to fulfill the purposes outlined in this notice, we may sometimes need to share your personal information with other individuals or organizations.

For example, we may share it with the following third parties:

- Your financial services advisor
- A person who has a product or service with us from which you are benefitting
- Other iA Financial Group entities and their representatives
- Credit bureaus and reporting agencies, such as Equifax or TransUnion
- Public and private insurance, fraud and claims databases
- Public bodies, such as the Société de l'assurance automobile du Québec or health care institutions
- Other insurers, reinsurers and financial institutions
- Your employer, union or association
- Partners who distribute our products and services, such as independent brokers, general agents, specialized insurance coverage providers, travel agencies or car dealerships
- Suppliers, for example of document printing, delivery or data storage services
- Courts, regulatory authorities or self-regulatory organizations
- Fraud prevention and management organizations, for example, law enforcement agencies

We may disclose your personal information outside of Canada

We store your personal information primarily in Canada, but we may sometimes disclose it to parties outside of Canada. For example, if we are doing business with a supplier based in another country. In this case, we contractually ensure that our supplier meets our expectations in terms of managing and protecting your personal information. Before we transfer your personal information outside of Canada, we ensure that it is adequately protected.

We may also disclose your personal information to another Canadian province or territory.

2.5 We obtain your consent, except in certain cases prescribed by law

When do we obtain your consent

We obtain your consent before we collect, use or disclose your personal information. We may obtain consent directly from you. It may also be obtained from another person, such as your financial services advisor, employer, car dealer, etc.

We will request your consent again if we wish to use or disclose your personal information for a purpose to which you have not consented.

When do we not request your consent

In some cases, the law permits us to collect, use or disclose your personal information without your consent.

Here are a few examples:

- Disclosing your personal information to suppliers for a purpose outlined in this notice, to provide you with the requested product or service
- Conduct statistical studies using de-identified personal information, where permitted by law
- Take appropriate action if we detect potential fraud
- In Quebec only: Using your personal information if it is clearly for your benefit or for purposes related to those to which you have already agreed
- Outside of Quebec: Using or disclosing your personal information if it is clearly for your benefit and we are unable to obtain your consent

We may also be required by law to disclose personal information. For example, if ordered by a court or requested by a regulatory authority or a self-regulatory organization.

2.6 We retain your personal information for a limited time

We retain your personal information only as long as necessary to:

- Fulfill the purposes for which we collected it, and
- Meet our legal obligations

We have implemented a retention schedule. It guides us as to how long we should keep each type of personal information, depending on the context. We destroy personal information once the retention period has elapsed. The duration of this period depends, among other things, on our legal and regulatory obligations and on the time needed to protect our rights in the event of legal recourse.

We may anonymize certain personal information before destroying it and retain a copy. Once the information is anonymized, it can no longer be used to identify you and is therefore no longer deemed personal. We use it, among other things, to improve our product pricing, identify trends and establish performance indicators.

2.7 We respect your privacy rights

Manage your consent preferences

You may review and change your consent preferences for the collection, use and disclosure of your personal information at any time. Please be aware, however, that we will no longer be able to offer you our products and services if you withdraw your consent for a purpose that is essential to our relationship with you (See the section *We collect your personal information for specific purposes* for further details).

For optional purposes, you may withdraw your consent at any time without adversely affecting our relationship with you.

You can contact us to withdraw your consent for the following purposes:

- Improve our products and services and provide a distinctive client experience
- Keep you informed of our promotions, products, services, contests and events that may be of interest to you

Withdrawing your consent may take up to 30 days to be processed and applied.

Accessing, rectifying or deleting your personal information

You have several rights regarding the personal information we hold about you. You may exercise them at any time.

Know whether we hold personal information about you	You can ask us: – If we hold personal information about you – How your personal information was collected, used and disclosed – If another person or organization holds your personal information for us
Access your personal information	You may ask to access the personal information we hold about you. You can also obtain a copy, but you may have to pay a reasonable fee for it. In some cases, we are unable to provide you with the requested information. For example: – We share certain medical information with your health care professional. This person can then explain it to you correctly. – We cannot give you information that would reveal information about another person.
Rectify your personal information	You can request that we rectify your personal information if it is incomplete or inaccurate. You can also update it if it has changed.
Delete your personal information	You can request that we delete your personal information. Our response will depend on the situation. If we have fulfilled the purposes for which the personal information was collected, we will delete it. However, we may retain it in order to meet our legal and regulatory obligations and protect our rights in the event of legal recourse. If we have not yet fulfilled the purposes for which the personal information was collected, we will delete the information that is out of date, inaccurate, incomplete or no longer required. If you request that we delete the rest of your personal information, we will no longer be able to offer you our products and services.

You may submit a written request to exercise any of your rights in relation to your personal information. You will receive our written response within 30 days. If we deny your request in whole or in part, we will provide you with several pieces of information:

- Reasons for the denial
- The references of the laws and regulations that justify this denial
- Your right to challenge this denial before the privacy regulatory authority of your province or territory
- Timeframe for appealing the denial

Filing a complaint

You may file a complaint if you feel that we have mishandled your personal information.

We invite you to contact us first if you wish to file a complaint. We will take the time to analyze your complaint and work with you to resolve the situation.

You can also file a complaint with the privacy regulatory authority of your province or territory.

3. How to contact us regarding your privacy

You can contact us in writing at the addresses below to:

- Submit a request to access, rectify or delete your personal information
- File a complaint about the handling of your personal information
- Request assistance, send us a comment or ask any question related to your privacy

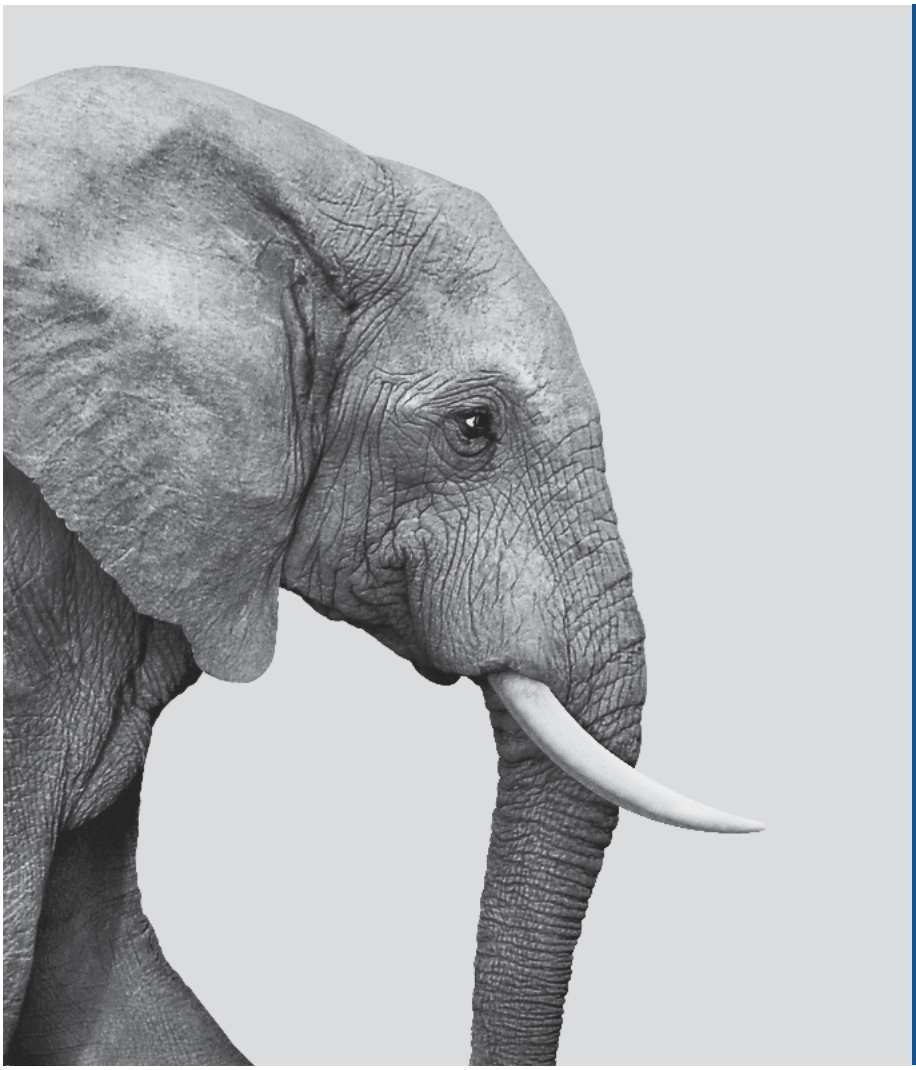
Make sure you provide us with all the information we need to follow up on your request.

By email: privacyofficer@ia.ca

By mail: Office of iA Financial Group Chief Privacy Officer
1080 Grande Allée West
PO Box 1907, Station Terminus
Quebec City, Quebec G1K 7M3

4. If we update this notice

We regularly update our practices to bolster them and ensure that they reflect changing privacy laws, regulations and standards. We will notify you on our website of any material changes to this notice.



F1A

About iA Financial Group

Founded in 1892, iA Financial Group offers life and health insurance products, mutual and segregated funds, savings and retirement plans, RRSPs, securities, auto and home insurance, mortgages and car loans and other financial products and services for both individuals and groups. It is one of the four largest life and health insurance companies in Canada and one of the largest publicly-traded companies in the country. iA Financial Group stock is listed on the Toronto Stock Exchange under the ticker symbol IAG.

F1A(25-05) 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 26 Wellington Street East Suite 600 Toronto, ON M5E 1S2	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.

ia.ca