

Critical Illness Insurance additional questions

(Questions 7 and 8 only need to be completed if you are applying for the Critical Illness Benefit)

Please provide details for each affirmative answer given, in the tables, on the previous page.

7. Have any of the proposed insureds experienced any history of optic neuritis, numbness, tingling, loss of balance, weakness of the extremities, visual disturbance or loss of sensation

Member	Spouse	Children			
Yes	No	Yes	No	Yes	No
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

8. FAMILY HISTORY

Have any of your family members had heart disease, stroke, high blood pressure, cancer (specify type), diabetes, kidney disease, Huntington's Chorea, amyotrophic lateral sclerosis (ALS/Lou Gehrig's disease), motor neuron disease, Multiple Sclerosis, Alzheimer's Disease or any other hereditary disease?

Yes No If yes, specify below

	Identify the family member	Illnesses (if cancer, please specify)	Age at the beginning of the illness	Age if living	Age at death
Member	<input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Brother <input type="checkbox"/> Sister				
	<input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Brother <input type="checkbox"/> Sister				
Spouse	<input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Brother <input type="checkbox"/> Sister				
	<input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Brother <input type="checkbox"/> Sister				

III- Confirmation/Authorization

I **HEREBY CONFIRM** that the statements contained in this Evidence of Insurability form and in any document attached hereto are complete and true, and **AUTHORIZE** the release of the information to Industrial Alliance for the purpose of assessing my insurability under the group plan.

I **AGREE** to submit to a blood test and a urinalysis, including but not limited to a test to detect exposure to the agent that causes AIDS, and I **ACCEPT** that the results be disclosed to Industrial Alliance so that my insurability can be evaluated.

I **UNDERSTAND** that the requested insurance is governed by the terms of the group insurance policy and will only take effect on the date determined by the terms of the policy once Industrial Alliance approves my insurability.

I **AUTHORIZE** any healthcare provider or professional, medical organization, insurance or reinsurance company, the Medical Information Bureau, workers' compensation board, the Policyholder, my employer, as well as any other person, public or private organization or institution holding files or information concerning myself, or if applicable, concerning my minor age children, to provide and exchange with Industrial Alliance, its employees, its reinsurers or their authorized agents, any information required to assess my, or my minor age child's, insurability under the group plan.

I **ALSO AUTHORIZE** Industrial Alliance, its employees and its reinsurers, to exchange with its subsidiaries and other insurers or financial institutions, the personal information obtained to review my insurability, or, if applicable, my minor age child's insurability, and to make inquiries so as to allow them to assess the risk.

I **ALSO AUTHORIZE** Industrial Alliance to send any abnormal test results to my personal physician.

This confirmation/authorization is valid for the purposes of the current group insurance policy. **A photocopy of this confirmation/authorization has the same value as the original.**

Date

Y	M	D

 Member's signature _____ Spouse's signature _____
 Signature of legal age child _____

Disclosure

At Industrial Alliance, the personal information we collect concerning you and your dependants is kept in strict confidence and is only used for the purposes you have authorized.

Your personal file will be kept at Industrial Alliance's offices.

You have the right to request access to your personal information and, if necessary, correct any inaccurate information. In order to do so, send a written request to the following: Industrial Alliance Insurance and Financial Services Inc., Access Officer, 1080 Saint-Louis Road, Silery, Quebec, G1K 7M3.

Access to your personal information will be limited to Industrial Alliance's employees, agents, reinsurers and service providers in the performance of their duties, individuals to whom you have granted access, and persons authorized by law.

For the purposes of audits and administrative reporting, Industrial Alliance may release to your employer/Policyholder statistical financial information without personal identifiers.

Industrial Alliance may establish a list of its insureds to share information within the Industrial Alliance Group. This will help us serve clients better and determine whether any products and services that the Industrial Alliance Group offers are suitable so we can offer such products and services to them. However, you are entitled to have your name removed from this list by making a written request to this effect to the Access Officer, as mentioned above.

Pre-notice from the Medical Information Bureau

Information regarding your insurability will be treated as confidential. Industrial Alliance and its reinsurers may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health coverage, or if a claim for benefits is submitted to such company, the MIB, will supply such company with the information it may have in its files upon request.

Upon receipt of a request from you, the MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of the information contained in the MIB's files, you may contact them and request a correction. The address of the MIB's information office is: Medical Information Bureau, 330 University Avenue, Suite 501, Toronto, Ontario, M5G 1R7; telephone: (416) 597-0590.

Industrial Alliance may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

IV- Authorization

I **AUTHORIZE** any healthcare provider or professional, medical organization, insurance or reinsurance company, the Medical Information Bureau, workers' compensation board, the Policyholder, my employer, as well as any other person, public or private organization or institution holding files or information concerning myself, or if applicable, concerning my minor age children, to provide and exchange with Industrial Alliance, its employees, its reinsurers or their authorized agents any information required to assess my, or my minor age child's, insurability under the group plan.

This authorization is valid for purposes of the current group insurance policy, its modification or extension. **A photocopy of this authorization has the same value as the original.**

Date

Y	M	D

 Member's signature _____ Spouse's signature _____
 Signature of legal age child _____