iA Financial Group

ENROLMENT REQUEST

GROUP INSURANCE

FOR PLAN ADMINISTRATORS

Please return original document to :
CCMC
835 Montée Masson, office 103
Terrebonne, Qc
J6W 2C7

TO BE COMPLETED AND SIGNED BY THE PLAN ADMINISTRATOR (Please print in ink)

Policyholder's name _____ **Group policy no.** _____
(Employer/Organization)

Division no. _____ Class no. _____ ☐ Certificate no. _____

Location no. or name (if applicable) _____ ☐ Certificate no. to be assigned by the insurer

Plan member's occupation _____

Employment date Y M D Eligibility date Y M D For reinstatement, date rehired full-time Y M D

If you waived the waiting period, please explain why: _____

Salary $ _____ ☐ Annually ☐ Biweekly ☐ Hourly – Hours worked/week _____
☐ Monthly ☐ Semi-monthly ☐ Weekly

Plan administrator's signature _____ Date Y M D

Plan administrator's email address _____ Tel. no. _____

TO BE COMPLETED AND SIGNED BY THE PLAN MEMBER (Please print in ink)

1. PLAN MEMBER INFORMATION

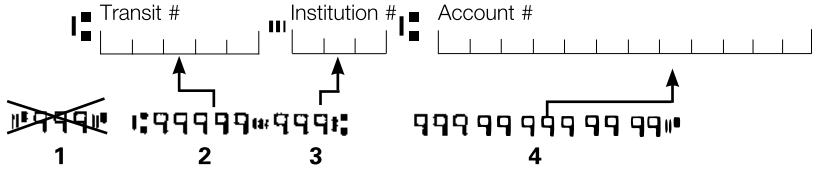
First name _____ Last name _____

Address _____ Postal code _____
No. Street Apt. City Province

Date of birth Y M D Gender: ☐ Male ☐ Female Language: ☐ English ☐ French

Direct deposit of your health and/or dental claim reimbursements and notification of claim processing

Banking information for direct deposit:



1 Cheque number (do not write this number).
2 Transit number (5 digits).
3 Financial institution number (3 digits).
4 Account number up to 12 digits. The format may vary from one financial institution to another.
Indicate all numbers and only the numbers.

Email address for notification: _____ ☐ Personal ☐ Work

⚠ **To receive notifications, you must provide your email address and your banking information.**

☐ I do not want to receive notification

You can view the status and details of your health and/or dental claims via My Client Space, our secure website, at any time.

Please complete all four pages of this form and sign the "PLAN MEMBER CONFIRMATION/AUTHORIZATION" section.

IMPORTANT: The basic dependents' life insurance coverage will be applied automatically if your plan includes this benefit and your dependents (spouse and children) are eligible. This requirement applies regardless of the coverage chosen for the health and dental benefits (individual, family, single-parent, couple or refused coverage).

2. SPOUSE INFORMATION

First name _____ Last name _____

Date of birth Y M D Gender: ☐ Male ☐ Female

Married : Yes ___ No ___
Cohabitation date for common-law spouse : _____

Does your spouse already have health and/or dental coverage under another group plan? ☐ Yes ☐ No

If yes, specify your spouse's:

Health coverage: ☐ Individual ☐ Family ☐ Single-parent ☐ Couple Effective date: Y M D

Dental coverage: ☐ Individual ☐ Family ☐ Single-parent ☐ Couple Effective date: Y M D

Insurer's name _____

Group policy no. _____ Certificate no. _____

Note: If your spouse is a common-law spouse, please contact your plan administrator to confirm his/her eligibility.

3. DEPENDENT CHILDREN INFORMATION *(if more space is required, please use another sheet. Date and sign any attached document.)*

First name	Last name	Gender	Date of birth	If age 21* or over, specify
		☐ M ☐ F	Y M D	Full-time student ☐ Yes ☐ No With a disability ☐ Yes ☐ No
		☐ M ☐ F	Y M D	Full-time student ☐ Yes ☐ No With a disability ☐ Yes ☐ No
		☐ M ☐ F	Y M D	Full-time student ☐ Yes ☐ No With a disability ☐ Yes ☐ No
		☐ M ☐ F	Y M D	Full-time student ☐ Yes ☐ No With a disability ☐ Yes ☐ No

* The age limit may vary depending on your plan. Please contact your plan administrator to confirm this information.

If any of your dependent children have coverage under a group insurance plan other than yours or your spouse's, complete the following table:

Child First name, Last name	Plan type (e.g. school plan, etc.)	Insurer name	Group policy no.

4. CHOICE OF COVERAGE

Coverage requested: ☐ Individual ☐ Family ☐ Single-parent[1] ☐ Couple[1]

[1] Select this coverage only if offered by your plan. Please be advised that if the single-parent and couple categories are not offered, you will automatically have family coverage.

Specify: Option/Module/Plan (if applicable) _____

If you and/or your dependents **already have health and/or dental coverage under another group plan**, you can refuse health and/or dental coverage under this group plan by checking the following boxes:

For myself and my dependents: ☐ I refuse health coverage ☐ I refuse dental coverage

For my dependents only: ☐ I refuse health coverage ☐ I refuse dental coverage

Note: If you refuse coverage and wish to request it at a later date, certain conditions may apply. Please contact your plan administrator for further details.

5. OPTIONAL BENEFITS

You can enrol in optional benefits to enhance your life, accidental death & dismemberment (AD&D) and critical illness insurance coverage. Before you enrol, please check with your plan administrator if optional benefits are offered as part of your group plan.

Are ExtensiA optional benefits offered as part of your group plan? You can enrol online. Simply go to My Client Space, our secure website, and under *ExtensiA – Optional Benefits*, click on *Online Enrolment*. You can also complete the *ExtensiA Application* form.

Are standard optional benefits offered as part of your group plan? Simply complete the table below. Please check with your plan administrator if you should complete the *Evidence of Insurability* form (F54-002A).

⚠ Please indicate the coverage amount to be added. Do not include basic coverage.

	Life	Accidental death and dismemberment	Critical illness	**Statement** (Complete only if you want to add optional life and/or optional critical illness benefits)
Plan member	$ _____	$ _____	$ _____	In the last 12 months, have you used, in any form whatsoever, tobacco, nicotine or cannabis mixed with tobacco? ☐ Yes ☐ No
Spouse	$ _____	$ _____	$ _____	In the last 12 months, has your spouse used, in any form whatsoever, tobacco, nicotine or cannabis mixed with tobacco? ☐ Yes ☐ No
Children	$ _____	$ _____	$ _____	Each child will benefit from the coverage amount you selected.

6. APPOINTMENT OF BENEFICIARY *(If you do not appoint a beneficiary, the benefit will be payable to the estate.)*

1. Primary beneficiaries

If you name multiple primary beneficiaries, the total allocation must be equal to or less than 100%. If less than 100%, the difference will be payable to the estate. Please do not indicate dollar amounts.

First name	Last name	Relationship	Date of birth	%
			Y M D	
			Y M D	
			Y M D	

2. Contingent beneficiaries

If you wish, you can also appoint contingent beneficiaries in the event all primary beneficiaries predecease you. If you name multiple contingent beneficiaries, the total allocation must be equal to or less than 100%. If less than 100%, the difference will be payable to the estate. Please do not indicate dollar amounts.

First name	Last name	Relationship	Date of birth	%
			Y M D	
			Y M D	

IMPORTANT: **• If your spouse is a common-law spouse, proceed to the next section. This box does not apply to you.**
• For Quebec residents only – to be completed if you appointed your spouse (by marriage or civil union) as a beneficiary.

In Quebec, the designation of a legal spouse (married or civil union) as beneficiary is irrevocable*, unless you check the following box:

☐ Revocable beneficiary

* To change the appointment of an irrevocable beneficiary, his/her written consent will be required.

Please sign the "PLAN MEMBER CONFIRMATION/AUTHORIZATION" section on the next page.

7. TRUSTEE DESIGNATION *(Not applicable in Quebec)*

⚠ In Quebec, there may be issues with respect to the appointment of a trustee. You should consult a legal advisor before appointing a trustee.

In all other provinces, you can complete this section. You can appoint a trustee to receive any amount due to any beneficiary under the age of majority.

Trustee's first name _____ Last name _____

PLAN MEMBER CONFIRMATION/AUTHORIZATION

I HEREBY APPLY for the benefits which I am eligible for under my Employer's/Policyholder's group insurance plan, subject to any refusal indicated and **CONFIRM** that the information contained in this form is true and complete to the best of my knowledge.

I CONFIRM that I am authorized to disclose information concerning my dependents and **I CONSENT**, on their behalf and on my own, to the release of the information provided to my Employer/Policyholder and Industrial Alliance Insurance and Financial Services Inc. ("iA Financial Group"), its employees, agents, reinsurers and service providers for the purpose of underwriting, administration, claims processing and the enrolment of myself and my dependents in my Employer's/Policyholder's group insurance plan.

If my Social Insurance Number is used as my certificate number, **I AUTHORIZE** its use for the administration of my group insurance plan.

I AUTHORIZE my Employer/Policyholder to make the required salary deductions for my group insurance plan.

If I enrol in direct deposit, **I AUTHORIZE** iA Financial Group to deposit in my bank account any amounts payable in regards to a claim, using the banking information provided in this form. **I AGREE** that this authorization will apply until such time as I submit a written request to the contrary to iA Financial Group. **I UNDERSTAND** that iA Financial Group will have no further obligation with regard to the claims paid. **I UNDERSTAND** that iA Financial Group can, without prior notice, terminate the direct deposit of my claims payments. This authorization takes effect on the date indicated below and will be valid for all other active bank accounts at this or any other financial institution that I may name in the future.

I ALSO UNDERSTAND and **AGREE** that if I provide iA Financial Group with incorrect banking information or if I fail to notify iA Financial Group of any change in my banking information and, as a result of this error or omission, the amount of a paid claim is deposited into the wrong bank account, iA Financial Group cannot be held responsible or liable for this error or omission or be obligated to reimburse me if iA Financial Group is unable to recover the amount that was paid into the wrong account.

I AGREE that a photocopy of this Confirmation/Authorization shall be as valid as the original.

Plan member's signature _____ Date Y M D

DISCLOSURE

At Industrial Alliance Insurance and Financial Services Inc. ("iA Financial Group"), the personal information we collect concerning you and your dependents is kept in strict confidence and is only used for the purposes you have authorized. Your personal file will be kept at iA Financial Group's offices.

You have the right to request access to your personal information and, if necessary, correct any inaccurate information. To do so, send a written request to: iA Financial Group, Information Access Officer, 1080 Grande Allée West, PO Box 1907, Station Terminus, Quebec City, Quebec, G1K 7M3.

Access to your personal information will be limited to employees, agents, reinsurers and service providers of iA Financial Group 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, iA Financial Group may release to your Employer/Policyholder statistical financial information without personal identifiers.