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GROUP INSURANCE

INDUSTRIAL ALLIANCE
INSURANCE AND FINANCIAL SERVICES INC.

Quebec
PO Box 790, Station B
Montreal, Quebec H3B 3K6

Ontario, Atlantic and Western Provinces
522 University Avenue, Suite 400
Toronto, Ontario M5G 1Y7

ENROLMENT REQUEST

TO BE COMPLETED BY THE PLAN ADMINISTRATOR

Policyholder's name (Employer/organization) **Group policy no.** |_|_|_|_|_|

Division no. |_|_| Class no. |_|_| Class name _____ ☐ Certificate no. |_|_|_|_|_|_|_|

Location no. (if applicable to your group): _____ ☐ Certificate no. to be assigned by the insurer

Member's occupation _____

Employment date: |_|_|_|_|_|_| Eligibility date: |_|_|_|_|_|_| For reinstatement, give date rehired full time: |_|_|_|_|_|_|

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

Salary $_____ ☐ Weekly ☐ Annually ☐ Bi-weekly ☐ Monthly ☐ Hourly Hours worked/week: _____

Administrator name _____ Email: _____

Signature _____ Date _____ Tel. no.: _____

TO BE COMPLETED BY THE MEMBER *(PLEASE PRINT CLEARLY.)*

1. MEMBER INFORMATION

Last name _____ First name _____

Address _____
Street City Province Postal code

Date of birth |_|_|_|_|_|_| Gender: ☐ Male ☐ Female Language: ☐ English ☐ French

Marital status: ☐ Single ☐ Divorced/Separated ☐ Married/Civil union ☐ Common-law spouse ➠ Cohabitation began on: |_|_|_|_|_|_|

Coverage requested: ☐ Individual* ☐ Family ☐ Other: _____ Specify Plan/Option/Module (if applicable) _____

*If you select ***Individual*** coverage, your dependents will not have any coverage, including dependent life. To include dependent life coverage, select ***Family*** coverage and complete sections 2, 3 and 4.

2. SPOUSE INFORMATION

Last name _____ First name _____ Date of birth |_|_|_|_|_|_| Gender: ☐ Male ☐ Female

Is your spouse covered by another group insurance plan for health and dental benefits from his/her employer or association? ☐ Yes ☐ No

If Yes, specify his/her coverage: **Health:** ☐ Individual ☐ Family ☐ Other: _____ **Dental:** ☐ Individual ☐ Family ☐ Other: _____

Insurer name: _____ Policy no.: _____ Certificate no.: _____

3. DEPENDENT INFORMATION

Last name	First name	Gender	Date of birth	If age 21 or over, specify:
Child		☐M ☐F	Y M D	Full-time student ☐Yes ☐No Handicapped ☐Yes ☐No
Child		☐M ☐F	Y M D	Full-time student ☐Yes ☐No Handicapped ☐Yes ☐No
Child		☐M ☐F	Y M D	Full-time student ☐Yes ☐No Handicapped ☐Yes ☐No

Note: If one of your dependent children is covered by a group insurance plan other than your spouse's plan, complete section 5.

4. WAIVER OF BENEFITS

If you or your dependents already have health and/or dental coverage under another group insurance plan, you can refuse the benefits by checking the appropriate boxes below.

I WAIVE HEALTH BENEFITS: ☐ for myself and my dependents ☐ for my dependents only

I WAIVE DENTAL BENEFITS: ☐ for myself and my dependents ☐ for my dependents only

If you waive coverage and wish to request it at a later date, certain conditions may apply.

PLEASE COMPLETE THE REVERSE SIDE AND SIGN THE MEMBER CONFIRMATION/AUTHORIZATION SECTION.

5. MULTIPLE COORDINATION OF BENEFITS *(To be completed only if your child is covered by another group insurance plan.)*

Child last and first name	Member name	Date of birth of the member	Insurer name	Policy no.

6. DIRECT DEPOSIT REQUEST FOR HEALTH AND DENTAL BENEFITS *(Please attach a void cheque.)*

☐ Yes, I am subscribing to **direct deposit** to have my health and dental claim reimbursements automatically deposited in my bank account, and to be informed by email when claims have been processed.

Banking information: Branch No. (5 digits) | Financial Institution No. (3 digits) | Bank Account No. Email: _____ ☐ Home ☐ Work

7. OPTIONAL BENEFITS *(Check with your plan administrator if optional benefits are offered in your group insurance contract and if an additional form is required.)*

	LIFE*	AD&D	CRITICAL ILLNESS	STATEMENT
Member	$_____	$_____	$_____	In the last twelve months, have any of the proposed insureds used tobacco in any form whatsoever, including nicotine products (gum, patches, etc.)? ☐ Yes ☐ No **Member's signature** X _____
Spouse	$_____	$_____	$_____	In the last twelve months, have any of the proposed insureds used tobacco in any form whatsoever, including nicotine products (gum, patches, etc.)? ☐ Yes ☐ No **Spouse's signature** X _____
Child	$_____	$_____	$_____	

* Do not include basic life insurance

8. BENEFICIARY DESIGNATION *(If no beneficiary is designated by the member, the benefit is payable to the estate.)*

Last name	First name	Relationship	%	Date of birth	
					☐ Revocable ☐ Irrevocable
					☐ Revocable ☐ Irrevocable
					☐ Revocable ☐ Irrevocable

In Quebec, if you do not indicate whether the beneficiary designation is revocable or irrevocable, the designation of the legal spouse is irrevocable and any other choice is revocable. In all provinces, an irrevocable beneficiary's written consent is required in order to make any change to the beneficiary designation.

The above beneficiary designation applies to the member's insurance. Claims for dependents will be payable to the member.

If one of the designated beneficiaries dies before the member, his/her share will be distributed proportionately with the other beneficiaries.

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

I appoint _____ as Trustee to receive any amount due to any beneficiary under the age of majority.

*In Quebec, there might be issues with respect to the appointment of a trustee. You should consult a legal advisor regarding this matter.

MEMBER CONFIRMATION/AUTHORIZATION

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

If applying for benefits for my dependents, **I CONFIRM THAT I AM AUTHORIZED** to disclose information concerning them for the purpose of determining their eligibility for coverage.

On behalf of myself and my dependents, **I CONSENT TO THE RELEASE** of the information contained in this form to my Employer/Policyholder and Industrial Alliance, 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 identification number, **I AUTHORIZE** its use for the administration of my group benefits.

If any contributions are required to be made by me with respect to my group benefits, **I AUTHORIZE** my employer to make any required deductions from my earnings and remit same to Industrial Alliance.

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

Member's signature _____ Date _____

DISCLOSURE

At Industrial Alliance, 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 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., 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 Industrial Alliance's employees, agents, reinsurers and service providers in the performance of their jobs, 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.