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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

GROUP INSURANCE

CHANGE OF RECORD

Please print in ink and sign.

1. BASIC INFORMATION

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

Division no. |_|_|_| Class no. |_|_|_| Location _____ Certificate no. |_|_|_|_|_|_|_|_|

Member's name (as shown on our records) _____

Authorized signature (administrator) _____ Date Y M D |_|_|_|_|_|_|_|_|

2. CHANGE OF NAME OR ADDRESS

Last name _____ First name _____

Reason: ❑ Correction ❑ Marriage/Civil union ❑ Divorced/Separated ❑ Moved Date Y M D |_|_|_|_|_|_|_|_|

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

Email _____

3. CHANGE OF COVERAGE *(Please specify the details in the dependents section, if applicable.)*

I want to change my coverage to: ❑ Individual* ❑ Family ❑ Other _____.

*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 3, 4 and 5.

Reason:

❑ Marriage/Civil Union – Date Y M D |_|_|_|_|_|_|_|_|

❑ Common-law – Spouse Cohabitation began on Y M D |_|_|_|_|_|_|_|_|

❑ Coverage under spouse's plan terminated – Termination date Y M D |_|_|_|_|_|_|_|_|

❑ Birth – Date Y M D |_|_|_|_|_|_|_|_|

❑ Divorced/Separated – Date Y M D |_|_|_|_|_|_|_|_|

❑ Coordination of benefits – Date Y M D |_|_|_|_|_|_|_|_|
(Proceed to section 6)

❑ Other _____ – Date Y M D |_|_|_|_|_|_|_|_|

Dependents:	**Last name**	**First name**	**Sex**	**Date of birth**	
❑ Add spouse ❑ Delete spouse			❑ M ❑ F	Y M D |_|_|_|_|_|_|	
❑ Add child ❑ Delete child			❑ M ❑ F	Y M D |_|_|_|_|_|_|	If the child is overage, based on the contract, go to section 4.
❑ Add child ❑ Delete child			❑ M ❑ F	Y M D |_|_|_|_|_|_|	

If your spouse is insured for Health and Dental Benefits, complete the "WAIVER OF BENEFITS" **and** "COORDINATION OF BENEFITS" sections.
If you want to apply for Optional Life Insurance on your spouse (if available), complete the "ADD OPTIONAL BENEFITS" section.

4. STATEMENT FOR OVERAGE DEPENDENTS

Last name _____ First name _____ Sex ❑ M ❑ F Date of birth Y M D |_|_|_|_|_|_|_|_|

If a full-time student, give name of educational institution: _____

Period: From Y M D |_|_|_|_|_|_| to Y M D |_|_|_|_|_|_|

If handicapped, nature of handicap: _____ Date handicap began Y M D |_|_|_|_|_|_|_|_|

Last name _____ First name _____ Sex ❑ M ❑ F Date of birth Y M D |_|_|_|_|_|_|_|_|

If a full-time student, give name of educational institution: _____

Period: From Y M D |_|_|_|_|_|_| to Y M D |_|_|_|_|_|_|

If handicapped, nature of handicap: _____ Date handicap began Y M D |_|_|_|_|_|_|_|_|

5. WAIVER OF BENEFITS *(available only if you and/or your dependents have coverage elsewhere)*

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 checked, please complete Section 7.
If you waive coverage and want to request it at a later date, certain conditions may apply. Contact your plan administrator for further details.

6. COORDINATION OF BENEFITS *(Completion of this section is mandatory for plans that include health and/or dental coverage.)*

❑ **My spouse does not have health and/or dental coverage (Disregard section 7.)**

❑ **My spouse has the following benefits**

Health: ❑ Individual ❑ Family ❑ Other _____ **Dental:** ❑ Individual ❑ Family ❑ Other _____

If checked, please complete Section 7.

If this change is not due to a **Life style** event, Evidence of Insurability is required.

YOU MUST COMPLETE AND SIGN THE *MEMBER'S CONFIRMATION AND AUTHORIZATION* ON THE REVERSE SIDE.

7. MANDATORY INFORMATION ON SPOUSE'S INSURANCE *(if applicable)*

Spouse's name _____ Spouse's group policy no. _____

Spouse's date of birth Y M D Spouse's certificate no. _____

Spouse's insurance company _____

8. ADD 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 you used tobacco in any form whatsoever or nicotine products (gum, patches, etc.)? ❑ Yes ❑ No **Member's signature X** _____
Spouse	$_____	$_____	$_____	In the last twelve months, has your spouse used tobacco in any form whatsoever or nicotine products (gum, patches, etc.)? ❑ Yes ❑ No **Spouse's signature X** _____
Child	$_____	$_____	$_____	

*Do not include basic life insurance.

9. TERMINATION OF OPTIONAL BENEFITS

	Optional Life	Accidental Death & Dismemberment	Critical Illness
I wish to terminate the following insurance for myself:	❑	❑	❑
I wish to terminate the following insurance for my spouse:	❑	❑	❑
I wish to terminate the following insurance for my dependent children:	❑	❑	❑

10. CHANGE OF BENEFICIARY DESIGNATION *(If no beneficiary is designated by the member then the benefit is payable to the estate.)*

Last name	First name	Relationship	%	Date of birth (Y M D)	
					❑ 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.

Irrevocable beneficiary's signature _____ **Date** Y M D

11. 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 AND AUTHORIZATION

I HEREBY CONFIRM that the information contained in this form is true and complete to the best of my knowledge.

If changing information on my spouse and/or dependent children, **I CONFIRM THAT I AM AUTHORIZED** to disclose information concerning them for the purpose of determining their coverage under my Employer/Policyholder's group plan.

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 purposes of underwriting, administration, claims processing and determining coverage for myself and my dependents in my Employer/Policyholder's group insurance plan. In addition, **I UNDERSTAND** that personal information may be subject to disclosure to those authorized under the applicable laws within or outside of Canada.

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

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

Member's signature _____ **Date** Y M D

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, QC 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.