INDUSTRIAL ALLIANCE
INSURANCE AND FINANCIAL SERVICES INC.

Group INSURANCE

CHANGE OF RECORD

Quebec and Atlantic Provinces
PO Box 790, Station B
Montreal, Quebec H3B 3K6

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

Please print in ink and sign.

Effective date of change: Y M D

BASIC INFORMATION

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

Division no. _____ Class no. _____ Location _____ Certificate no. _____

Member's name (Please record you old name, if name change is being requested) _____

CHANGE OF NAME OR ADDRESS

Last name _____ First name _____

Reason: ❑ Correction ❑ Marriage/ Civil Union – Date Y M D ❑ Divorced / separated – Date Y M D

Address _____ Postal code _____
No. Street City Province

CHANGE OF STATUS *(Please specify the details in the dependents section.)*

I wish to change my status to: ❑ Individual ❑ Family ❑ Other: _____

Reason:

❑ Marriage / Civil Union – Date Y M D
❑ Divorced / Separated – Date Y M D
❑ Common-law – Date cohabitation began: Y M D
❑ Other – Date Y M D
❑ Coverage under spouse's plan terminated – Termination 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		Full-time student ❑ Yes ❑ No	Handicapped ❑ Yes ❑ No
❑ Add child ❑ Delete child			❑ M ❑ F		Full-time student ❑ Yes ❑ No	Handicapped ❑ Yes ❑ No

If your spouse is insured for Health and Dental Benefits, please complete section entitled "COORDINATION AND WAIVING OF BENEFITS".
If you should wish to apply for Optional Life Insurance on your spouse (if available), please complete the section entitled "CHANGE IN OPTIONAL BENEFITS".

OVERAGE DEPENDENTS STATEMENT

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

If a full time student, name of educational institute attending _____

Period: From: Y M D to Y M D

If handicapped, nature of handicap _____ Date handicap commenced Y M D

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

If a full time student, name of educational institute attending _____

Period: From: Y M D to Y M D

If handicapped, nature of handicap _____ Date handicap commenced Y M D

COORDINATION AND WAIVING OF BENEFITS *(To complete only if you and/or your dependents are covered for similar benefits under another plan.)*

Check the appropriate boxes:

Coverage of the spouse's plan

Health: ❑ Individual ❑ Family ❑ Waived
Dental: ❑ Individual ❑ Family ❑ Waived

Waiving the member's coverage

❑ Health Insurance
❑ Dental Care Insurance

Waiving the dependent's coverage

❑ Health Insurance
❑ Dental Care Insurance

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

Spouse's certificate no. _____ Spouse's certificate no. _____

Spouse's insurance company _____

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

YOU MUST COMPLETE THE *MEMBER'S CONFIRMATION AND AUTHORIZATION* ON THE REVERSE SIDE.
FAILURE TO DO SO WILL RESULT IN YOUR CHANGE NOT BEING PROCESSED.

F54-070A

CHANGE IN OPTIONAL BENEFITS *(Check with your plan administrator if optional benefits are offered in your group insurance contract.)*

	LIFE	AD&D
Member	$_____	$_____
Spouse	$_____	$_____
Child	$_____	$_____

STATEMENT

In the past 12 months, have you smoked or used cigarettes,cigarillos, cigars, pipe, chewing tobacco, nicotine gum or patches or any other tobacco product?

❑ Yes ❑ No **Member's signature** _____

❑ Yes ❑ No **Spouse's signature** _____

TERMINATION OF OPTIONAL BENEFITS

❑ I wish to terminate my Optional Life Insurance.

❑ I wish to terminate the Opt. Life Insurance on my spouse.

❑ I wish to terminate the Opt. Life Insurance on my dependents.

❑ I wish to terminate my Accidental Death & Dismemberment Insurance (AD&D).

❑ I wish to terminate the AD&D Insurance on my spouse.

❑ I wish to terminate the AD&D Insurance on my dependents.

CHANGE OF BENEFICIARY DESIGNATION

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.
If no beneficiary is designated by the member then the benefit is payable to the estate.
To replace a previously designated irrevocable beneficiary, please obtain his/her signature.

Irrevocable beneficiary's signature _____ **Date** _____

TRUSTEE DESIGNATION *(Complete only if the beneficiary has not reached legal age.)*

I designate the person whose name appears below to act as trustee to receive any amount payable to a beneficiary who is under the legal age or does not have the legal capacity to provide a release. I declare that the release of the said trustee will constitute a valid release for Industrial Alliance with respect to the amount paid.

Trustee's name _____ Social insurance number |_|_|_|_|_|_|_|_|_|

Member's signature _____ Date _____

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's/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'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.

I AGREE that a photocopy copy 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 so, send a written request to the following: Industrial Alliance Insurance and Financial Services Inc., Access Officer, 1080 Saint-Louis Road, Sillery, 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.

Industrial Alliance may establish a list of its insureds to share information within the Industrial Alliance Group. This will help us serve them 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 referred to above.