iA Financial Group

APPLICATION FOR INPATRIATE HOSPITAL/MEDICAL INSURANCE (EMPLOYEE PLAN)

Group Policy No. 100002173	**Name of Policyholder: THE INVESTMENT GUILD**	**q New**
Division No.	**Name of Division:**	**q Extension**

EMPLOYEE INFORMATION (PLEASE PRINT BOLDLY IN INK)

Last Name |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__| Given Name |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__| Initial |__|

Canadian Mailing Address
|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|

City |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__| Province |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__| Postal Code |__|__|__| - |__|__|__|

Sex
q (M)
q (F)

Date of Birth |_____|_____|_____|
(*dd / mmm / yyyy*)

Country of Origin |_____|

Telephone Number (|__|__|__|) |__|__|__| - |__|__|__|__|

Requested Term of Coverage: From |_____|_____|_____| (*dd / mmm / yyyy*) To |_____|_____|_____| (*dd / mmm / yyyy*)

SPOUSE AND DEPENDENT INFORMATION (IF TO BE COVERED) (PLEASE PRINT BOLDLY IN INK)

(Note: Spouse and Dependent Children can only be insured if Employee is also covered under the plan)

Requested Term of Coverage: From |_____|_____|_____| (*dd / mmm / yyyy*) To |_____|_____|_____| (*dd / mmm / yyyy*)

Last Name	Given Name	Relationship	Sex	Date of Birth
|__|__|__|__|__|__|__|__|__|__|__|	|__|__|__|__|__|__|__|__|__|__|__|	|_____|	**q** (M) **q** (F)	|_____|_____|_____| (*dd / mmm / yyyy*)
|__|__|__|__|__|__|__|__|__|__|__|	|__|__|__|__|__|__|__|__|__|__|__|	|_____|	**q** (M) **q** (F)	|_____|_____|_____| (*dd / mmm / yyyy*)
|__|__|__|__|__|__|__|__|__|__|__|	|__|__|__|__|__|__|__|__|__|__|__|	|_____|	**q** (M) **q** (F)	|_____|_____|_____| (*dd / mmm / yyyy*)
|__|__|__|__|__|__|__|__|__|__|__|	|__|__|__|__|__|__|__|__|__|__|__|	|_____|	**q** (M) **q** (F)	|_____|_____|_____| (*dd / mmm / yyyy*)

(If more space is needed for dependents, please attach a separate sheet providing required details)

DECLARATION AND AUTHORIZATION

I understand that any group insurance resulting from this application is subject to approval by Industrial Alliance Insurance and Financial Services Inc., ("iA") and to all provisions of the master group policy issued to the Policyholder. I also understand that coverage will not be provided for any "Pre-Existing Condition". "Pre-Existing Condition" means any condition, Injury or Sickness for which the Employee, Spouse or Dependent Children received medical advice, consultation or treatment six (6) months prior to the effective date of his insurance with the exception of a chronic condition which is under treatment and stabilized by the regular use of prescribed medication.

I declare that as of the date of this application, I, my spouse and/or dependent children are performing our normal activities on a daily basis.

I authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, or any other organization, institution or person that has any records or knowledge of me, my spouse and/or my dependent children, or our health, to release to iA or their reinsurers any such information.

I acknowledge receipt of the Notice on Privacy and Confidentiality (shown below) summarizing certain privacy practices regarding collection, use and disclosure of personal information. My signature below also indicates acknowledgement on behalf of my spouse and/or dependent children, if included on this application.

A photostatic copy of this authorization shall be valid as the original.

_____ _____

Employee Signature Date Signed *(dd/mmm/yyyy)*

NOTICE ON PRIVACY AND CONFIDENTIALITY (Please read carefully and note for your records)

The specific and detailed information requested pursuant to this application from you and which may be subsequently requested by us, from time to time, is required to process your application, and process any claim for benefits made by you. To protect the confidentiality of such personal information, access to your information is restricted to any person you authorize or as authorized by law as well as those Industrial Alliance Insurance and Financial Services Inc. ("iA") employees, third party administrators, mandataries, agents or brokers of iA, reinsurers, plan sponsors and any agents or brokers of such sponsors or other market intermediaries who are responsible for (a) sponsoring a plan for you, (b) marketing and administration of products or services, (c) assessment of risk (underwriting) and (d) investigation of claims. ***Your file will be kept in iA's offices.***

You are entitled to review your personal information contained in our files, subject to certain limited exceptions established by law, and if necessary, to have it rectified by sending a written request to us at: 2165 West Broadway. P.O. Box 5900, Vancouver, B.C. V6B 5H6, Attention: Manager, Group Administration, Special Markets Solutions. Corrections will be noted in the file. If a requested correction is in dispute, we nonetheless note your requested correction in the file. Further information on our privacy practices can be found at our *website* *www.inalco.com* or alternatively, contact us at 1-800-266-5667 and request that a copy be faxed or mailed to you.

iA Financial Group is a business name and trademark of Industrial Alliance Insurance and Financial Services Inc.