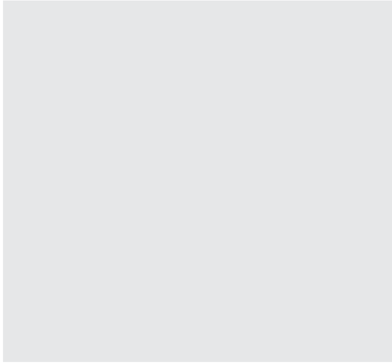
Cancer Guard

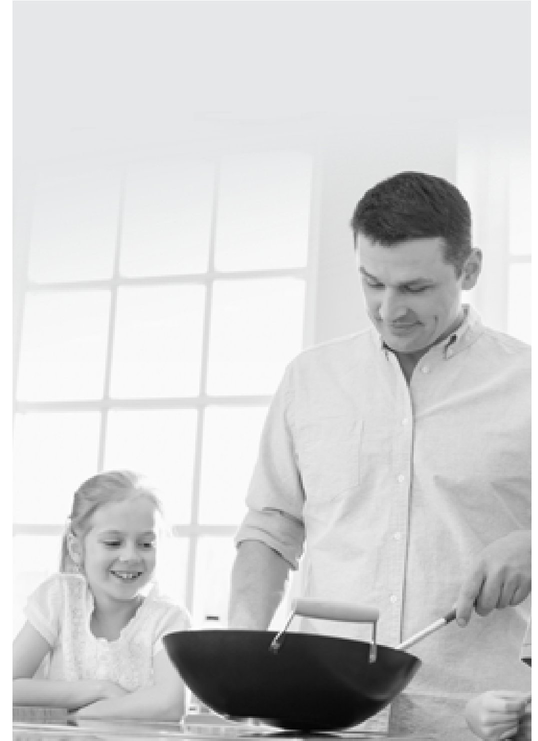
F43A
Application

New sale ☐

Change in coverage ☐

Contract #





Name of representative	Email address of representative*	Code	%
Name of representative	Email address of representative*	Code	%
Firm	Email address of firm*	Code	

* If your current email on file has not changed, please leave this field blank.

INVESTED IN YOU.

F43A(20-01)

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

1 GENERAL INFORMATION (Primary insured)

Last name

First name

Email address

Date of birth Y | M | D ☐ Save age

Gender ☐ F ☐ M

Smoking status ☐ Non-smoker ☐ Smoker*

* You are considered a smoker if during the past twelve months, you have used tobacco or tobacco derived products in any form, regardless of the frequency of use.

Home address no. | street | apt./condo

City

Province

Postal code

Home/Cell phone number

Office phone number

Ext.

Legal status ☐ Canadian citizen ☐ Permanent resident ☐ Other

In Canada always ☐ or since Y | M | D

Language of correspondence
☐ French ☐ English

2 POLICYHOLDER (To be completed if other than primary insured)

Last name

First name

Home address ☐ Same as the primary insured
no. | street | apt./condo

City

Province

Postal code

Home/Cell phone number

Date of birth Y | M | D

Gender ☐ F ☐ M

Relationship to primary insured

3 BENEFICIARY

☐ Policyholder **Or** ☐ Primary insured **Or**

⚠ The lack of designation constitutes a revocable designation in favour of the policyholder.

Last name	First name	Gender	Distribution	Status	Relationship to primary insured
Beneficiary 1		☐ F ☐ M	%	Revocable ☐ Irrevocable ☐	
Contingent beneficiary		☐ F ☐ M		Revocable ☐ Irrevocable ☐	
Beneficiary 2		☐ F ☐ M	%	Revocable ☐ Irrevocable ☐	
Contingent beneficiary		☐ F ☐ M		Revocable ☐ Irrevocable ☐	

4 ELIGIBILITY

The eligibility questions are used to determine the client's premium rate: STANDARD, PREFERRED or PREFERRED PLUS. For each level, the eligibility grid matches the questions required to the maximum amount of coverage.

INSURANCE	PREREQUISITE	STANDARD RATE up to $50,000	PREFERRED RATE up to $100,000	PREFERRED PLUS RATE up to $150,000
Cancer	If you have answered **NO** to the following questions:	1 - 2A	1 - 2A - 3 - 4A	1 - 2A - 3 - 4A - 5A
Critical illness	If you have answered **NO** to the following questions:	1 - 2A - 2B	1 - 2A - 2B - 3 - 4A - 4B	All questions

Eligibility questions for STANDARD RATE ($5,000 to $50,000)	**Yes**	**No**
1- In your lifetime, have you ever been diagnosed with acquired immunodeficiency syndrome (AIDS) or tested positive for the human immunodeficiency virus (HIV)?	☐	☐
2- Do you have, have you ever had, have you noticed signs or symptoms for which you have not consulted a physician yet, or are you waiting for a test or test results for any of the following illnesses or medical conditions: **A▸** Leukemia, lymphoma, malignant tumour or any form of cancer?	☐	☐
To be answered only if the primary insured is applying for critical illness optional coverage **B▸** Chronic neurodegenerative diseases, type 1 (insulin-dependent) diabetes, type 2 diabetes, congenital heart abnormality, angina, angioplasty, coronary artery bypass surgery, heart attack, heart failure, cardiomyopathy, heart valve disease, stroke (cerebrovascular accident), transient ischemic attack (TIA), any other cerebrovascular disease, any other disorder of the heart or blood vessels, abnormal electrocardiogram (ECG), chronic renal failure or polycystic kidney disease?	☐	☐

Eligibility questions for PREFERRED RATE ($5,000 to $100,000)	**Yes**	**No**
3- In the past two years, have you had an application for critical illness or cancer insurance declined or deferred by any insurance company, including iA Financial Group?	☐	☐
4- Have two or more members of your immediate family (father, mother, brothers and sisters) suffered from or been diagnosed before the age of 60 with: **A▸** Cancer?	☐	☐
To be answered only if the primary insured is applying for critical illness optional coverage **B▸** Heart disease, stroke or a transient ischemic attack (TIA)?	☐	☐

Eligibility questions for PREFERRED plus RATE ($5,000 to $150,000)	**Yes**	**No**
5- Has one or more members of your immediate family (father, mother, brothers and sisters) suffered from or been diagnosed before the age of 60 with: **A▸** Breast or ovarian cancer, colorectal cancer or familial adenomatous polyposis?	☐	☐
To be answered only if the primary insured is applying for critical illness optional coverage **B▸** Polycystic kidney disease, Huntington's disease or motor neuron disease?	☐	☐

5 SUMMARY OF REQUESTED COVERAGES (minimum annual premium: $100)

COVERAGE	**CANCER**		**CRITICAL ILLNESS**	**ROP**	**MONTHLY PREMIUM**	**TOTAL PREMIUM**
	SUM INSURED	PREVENTION	SUM INSURED			
Term 10	$	☐	$	☐	$	
Term 20	$	☐	$	☐	$	
Term 75	$	☐	$	☐	$	
OPTIONAL COVERAGE				**SUM INSURED**		$
ACCIDENTAL DEATH, DISMEMBERMENT OR LOSS OF USE (From $25,000 $ to $350,000 by increments of $25,000)				$	$	
ACCIDENTAL FRACTURE (1 unit: $5,000, 2 units: $10,000)				$	$	
EXTENDED MEDICAL CARE FURTHER TO AN ACCIDENT (Monthly premium: $2.50)				☐	$	

6 METHOD OF PAYMENT

I hereby authorize Industrial Alliance Insurance and Financial Services Inc. ("iA Financial Group") to draw monthly payments from my bank account at my financial institution for the purpose of paying the insurance premium. This authorization concerns pre-authorized debits in the "personal" category. I will receive, at least **ten days** before any change in the date of the debit or in the amount to be debited, a notice to this effect. I will receive a notice in the event of insufficient funds ("NSF"), stop payment or account closed. Note that an administrative fee will apply to any dishonoured payment and will be payable at the same time as the returned amount and at the next regular payment. Please note that the first pre-authorized debit will be adjusted to reflect the actual period between the first premium paid, the effective date of the coverages and the date you chose for the debits. Future debits will correspond to the monthly premium.

I may cancel or change this pre-authorized debit agreement at any time, subject to providing iA Financial Group 30 days' notice in writing. I have certain recourse rights if any pre-authorized debit does not comply with this agreement. For example, I have the right to receive reimbursement for any debit that is not authorized or is not consistent with this agreement. To obtain a sample cancellation or reimbursement form or for more information on my recourse rights, I should contact my financial institution or visit www.payments.ca. For more information, please contact our Customer Service in Montreal at 1-800-465-5818 or by email at livingbenefits@ia.ca.

☐ **Annual premium** → Please make your cheque out to **iA Financial Group.**

First premium	Subsequent premiums
☐ Cheque attached made out to **iA Financial Group.**	☐ Pre-authorized debit on the ______ of each month (1st to 28th)
☐ Pre-authorized debit (upon receipt of application)	If no date is given, premium will be withdrawn on effective date of the contract.

Please attach a specimen cheque marked "Void"
OR please give us the name of your financial institution ______

Transit number ______ (5 digits) Bank number ______ (3 digits) Account number ______ (write all digits)

	X	Y | M | D
Last name and first name of payor	Signature (as it appears on cheques)	Date

7 DECLARATION

I understand and accept that:

1) the information provided in this application is true and complete and acknowledge that it constitutes the basis for insurance coverage;
2) if any misrepresentation or omission is made, the Insurer shall not be held to any obligation under any insurance that may be issued to me further to acceptance of my insurance application;
3) all benefits payable are subject to the conditions, definitions, limitations and exclusions set out in the contract. I further confirm that my representative has had the opportunity to explain the details of the contract to me;
4) this insurance coverage will take effect from the date on which the application is received to the Insurer's Montreal office;
5) I undertake to inform the Insurer of any change in my insurability, including my health, between the time of signature of this application and the date the requested contract will be in force;
6) iA Financial Group, its affiliates and their agents can access information about me in order to know me better, better meet my needs and offer the best possible service and client experience. (If you do not wish to allow this access, please send a written request to: iA Financial Group, Policyowner Services, 1080 Grande Allée West, PO Box 1907, Station Terminus, Quebec City, QC G1K 7M3.)

Signed at ______ City Date Y | M | D

X	X	X
Signature of primary insured	Signature of policyholder (if other than primary insured)	Signature of representative