iA Financial Group

ENROLMENT REQUEST
ACTIVE MEMBERS OF QPAT

Mail: Administration
PO Box 790, Sation B
Montreal, QC H3B 3K6

Fax: 1-888-780-2376
Email: groupinsurance@ia.ca

TO BE COMPLETED AND SIGNED BY THE PLAN ADMINISTRATOR (Please print in ink)

School Board's name _____ **Group policy no:** ☐ 97000 ☐ 97001

Division no. _____ Class no.: ☐ Full time 100 ☐ Part-time 200 ☒ Certificate no. to be assigned by the insurer

Badge no. _____ Eligibility date Y M D _____ Gross annual salary $ _____

Plan administrator's signature **X** _____ Date Y M D _____

Plan administrator's email _____ Tel. no. _____

TO BE COMPLETED AND SIGNED BY THE PARTICIPANT (Please print in ink)

1. IDENTIFICATION OF THE PARTICIPANT

Last name _____ First name _____

Address _____ Postal code _____
N. Street Apt. City Province

Date of birth Y M D _____ Sex: ☐ M ☐ F Language: ☐ E ☐ F

Email* (optional) _____

Direct deposit of your health and/or dental claim reimbursements and notification* of claim processing

Banking information for direct deposit: _____ _____ _____
Transit no. (5 digits) | Institution no. (3 digits) | Account no.

☐ I want to be notified by email of the status of my claims ☐ I do not want to be notified

* Your email address will be used to send you information about your group plan and for notification purposes only.

2. CHANGE OF BENEFITS

	FULL TIME TEACHER	PART-TIME TEACHER
Health Insurance • Participant only • Participant and spouse • Participant and children • Participant, spouse and children	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ **Type of coverage for dependents** ☐ Prescription drug only ☐ Full benefit
☐ **Exemption –** I request to be exempted from the health insurance benefit because I am covered as a dependent under my spouse's plan. Spouse's name _____ Insurer _____ Policy no. _____		
Participant's Basic Life Insurance (optional) ☐ None, or choose from 1 to 6 units of $25,000	☐ Add _____ units	☐ Add _____ units
Participant's Additional Life Insurance (optional) ☐ None, or choose from 1 to 4 units of $25,000 *Note -You need to select 6 units of basic life insurance to be eligible for additional life insurance.	☐ Add _____ units*	☐ Add _____ units*
Dependent's Life Insurance (optional) • None • Spouse only • Children only • Spouse and children	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐
Long-Term Disability Income Insurance (optional for part-time employees)	☐ Add ☐ Exemption**	☐ Yes ☐ No

**** Long-Term Disability Income Insurance exemption (full-time only)**

Effective date of the exemption Y M DJ _____ Reason _____

3. DEPENDENT INFORMATION *(To be completed if you want to insure your dependents for life or health insurance)*

Last name	First name	Sexe	Date of birth	
Spouse		☐ M ☐ F	Y M D	Date of marriage: Y M D OR cohabitation since: Y M D
Child		☐ M ☐ F	Y M D	If age 18 or over, specify ☐ Full-time student ☐ Disabled
Child		☐ M ☐ F	Y M D	If age 18 or over, specify ☐ Full-time student ☐ Disabled
Child		☐ M ☐ F	Y M D	If age 18 or over, specify ☐ Full-time student ☐ Disabled

[1] If your spouse is a common-law spouse, the cohabitation period must be minimum one year.

4. APPOINTMENT OF BENEFICIARY *(If you do not appoint a beneficiary, the benefit will be payable to the estate)*

If you name multiple beneficiaries, the total allocation must be equal to or less than 100%. If less than 100%, the difference will be payable to the estate. Please do not indicate dollar amounts.

Last name	First name	Relationship	Date of birth	%
			Y M D	
			Y M D	
			Y M D	

IMPORTANT: For Quebec residents only – to be completed if you appointed your spouse (marriage or civil union) as a beneficiary.

In Quebec, the designation of a spouse, excluding a common-law spouse, as a beneficiary is irrevocable* unless you check the following box:

☐ Revocable beneficiary

* To change the appointment of an irrevocable beneficiary, his/her written consent will be required.

PLAN 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 Insurance and Financial Services Inc. (the Company), 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 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 the Company.

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 Insurance and Financial Services Inc. (the Company), 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 the Company's offices.

You have the right to request access to your personal information and, if necessary, correct any inaccurate information. To do so, send a written request to: 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 employees, agents, reinsurers and service providers of the Company in the performance of their duties, individuals to whom you have granted access, and persons authorized by law. For the purposes of audits and administrative reporting, the Company may release to your Employer/Policyholder statistical financial information without personal identifiers.

NOTE: Send one copy to your School Board and the original to the Company. Keep one copy for your files.