

## Process to fill out Alternative Whole Life Application

You have two options in filling out this application.

1. Print the application and fill out the required information in pen.
2. Fill out the blue highlighted areas on your computer then Print the completed application and sign where requested below.

### **PAGE 1**

#### **Proposed Insured**

Please complete all section 1- 5

#### **Requested Coverage**

Please fill out Section 1 and 3. We will complete section 2 once you have decided what plan option you want.

#### **Applicant**

Please fill out Section 1 – 5 if the Proposed insured is not the owner, (Business Insurance)

### **PAGE 2**

Please read the declaration and sign where highlighted. Signed at City, Province, this, Day of 2011.

### **PAGE 3**

Please fill out banking information and sign as the account holder at the bottom of the page

### **PAGE 4**

Please fill out Name, Address and sign at the bottom of the page.

**Please send the completed application to New Business at the address below.  
We will immediately notify you when we have received your application.**



Application no.

A

F2A-P

ALTERNATIVE | Permanent Life Insurance

Proposed insured

Policy no.

1 Last and first name Last name First name Initials

2 Address No. Street Apartment PO Box  
City Province Postal code

3 Date of birth Date of birth (D M Y) Age Sex (M/F) Last name at birth (if applicable) Place of birth (province or country) In Canada since Social Insurance Number

4 Telephone Home phone no. Work phone no. Extension Email address

5 Beneficiary Last and first name Sex (M/F) Date of birth (D M Y) % Relationship to proposed insured (Revocable/Irrevocable)

Requested coverage – A maximum of \$150,000 applies to the total Alternative permanent, Alternative term and Perspective in force insurance for the same insured with Industrial Alliance group.

1 Insurance \$ Minimum: \$5,000 Maximum: \$10,000 (up to age 24) \$50,000 (age 25 and over)

2 Premium  Limited pay  Payable for life  Level  Indexed amount (3%)  
If no instructions are given, face amount will be level and premium payable for life

Total premium \$ Premium paid with application \$  
A deposit is mandatory  
Mode of payment  PAC (complete section overleaf)  Annual

3 Tobacco use Have you used any kind of tobacco in the past twelve months, including nicotine or tobacco products (gum, patch, etc.)?  
 Yes -> Smoker rate  No -> Non-smoker rate (answer the following question)  
Have you ever used tobacco?  Yes  No If yes, when did you quit? (M Y)

Applicant (Complete if other than proposed insured.)

1 Last and first name Last name First name Initials

2 Address No. Street Apartment PO Box  
City Province Postal code

3 Date of birth Date of birth (D M Y) Age Sex (M/F) Relationship to proposed insured

4 Telephone Home phone no. Work phone no. Extension Email address

5 Contingent policyowner

Agent

1 Last and first name Code S.U. Agency Code  
Churchill Insurance Brokerage Services Inc. | 1 9 7 3 | 4 3 | 9 9 | Churchill Insurance Brokerage Services Inc. | R 9 | 2

Special instructions

**Declaration of the proposed insured**

We, the proposed insured and the applicant, declare that:

- The proposed insurance does not totally or partially replace another insurance policy presently in force;
- The proposed insured is currently capable of carrying out by himself/herself any basic activities of daily living such as: getting up, walking, washing, dressing, eating and is not suffering from incontinence;
- The proposed insured is not under guardianship;
- The proposed insured child is capable of carrying out by himself/herself all basic activities of daily living according to his (her) age;
- The proposed insured is not currently admitted to a hospital, clinic or extended-care facility OR a resident of a health establishment such as a nursing home OR a residential care centre OR a resident of a home for individuals with reduced physical or mental autonomy;

- The proposed insured is not currently being tested for and has not been diagnosed with, informed of or treated for any type of cancer during the past 3 years;
- The proposed insured has not been informed that he/she has tested positive for the human immune deficiency virus (HIV);
- The proposed insured does not have Acquired Immune Deficiency Syndrome (AIDS) or any AIDS-related disease;
- In the last six months, the proposed insured has not used drugs such as opium, heroin, morphine, codeine, Demerol, barbiturates, amphetamines, cocaine, hallucinogens and anabolic steroids, other than as prescribed by a doctor, or methadone as prescribed or not by a doctor.
- We understand that if death, other than accidental, occurs within the first two (2) years the contract is in force, the death benefit paid will be an amount equal to all premiums paid, plus 5% interest.

The Company reserves the right to make an evaluation based on criteria other than those mentioned above.

**Signatures**

We, the proposed insured and the applicant, declare that all answers and explanations given in this application, or in any other questionnaire in connection herewith, are true and complete.

We agree that the insurance takes effect as of the acceptance of the application by the Company inasmuch as the latter has been accepted without modification, the first premium has been paid and no change has taken place in the insurability of the proposed insureds since the signing of the application.

We hereby authorize any health care professional as well as any other public or private health or social service establishment, any insurance company, the Medical Information Bureau, financial institutions, personal information agents or detective agencies and any public body holding information concerning ourselves or our family, particularly medical information, to supply this information to INDUSTRIAL ALLIANCE PACIFIC and its reinsurers for the risk assessment or the investigation necessary for the study of any claim.

We also authorize our insurer, or its reinsurers, to exchange the personal information contained in this application with other insurers, or financial institutions, and to inquire of them for the appraisal of the risk or in the event of a claim.

In case of death or disability, the beneficiary, the heir or the liquidator of my estate, is expressly authorized to supply INDUSTRIAL ALLIANCE PACIFIC, when required by the latter, with all information and authorizations necessary to study the death benefit and obtain the required justifications.

By signing below, the agent confirms that he has provided a disclosure statement to the applicant which discloses the company or companies he represents and his relationship with them; that he receives compensation (such as commissions) for the sale of insurance products and may receive other compensation such as bonuses, invitations to conferences or other incentives; and any conflicts of interest that he may have with respect to this transaction.

**We agree that a photocopy of this authorization shall be as valid as the original.**

Signed at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_\_

|                         |           |          |
|-------------------------|-----------|----------|
| <b>Proposed insured</b> | Applicant | Agent    |
| <b>X</b>                | <b>X</b>  | <b>X</b> |

**Disclosure notice**

The transaction to which this application applies concerns the policyholder and Industrial Alliance Pacific Insurance and Financial Services Inc. The licensed representative who submits this application represents Industrial Alliance Pacific and will receive compensation from the Company once the transaction is completed. This

application includes no other condition which obligates the policyholder to conduct other business with the representative, Industrial Alliance Pacific or any other organization.

## Pre-Authorized Cheque Payments (PAC) Agreement

Each account holder is referred to as "I" in this PAC Agreement section and makes the following statements in respect to himself or herself.

- I authorize Industrial Alliance Pacific Insurance and Financial Services Inc. (the "Company") and the financial institution designated (or any other financial institution I may authorize at any time) to begin deductions as per my instructions for regular recurring payments and/or one-time payments from time to time, for payment of all premiums, deposits, instalments and charges arising from the contract hereunder mentioned. Regular payments will be debited from my specified account based on the date and/or frequency I have chosen, whereas one-time payments from time to time can be debited from my account on any other date.
- I agree that, for the purpose of this PAC Agreement, all PACs from my account will be treated either as Personal or Business\* depending on the choice I make here below.
- I waive the right to receive pre-notification of an increase or a decrease in the amount to be debited or a change in the date and/or frequency of these payments.**
- I agree that the Company is not required to provide me with written notice of a change in a PAC amount that is made as a result of my request.
- If a PAC is dishonoured for any reason such as, but not limited to, insufficient funds ("NSF"), stop payment or account closed, the Company is authorized to re-submit the payment. **Any charges incurred by the Company as a result of the dishonoured PAC will be added to the subsequent PAC.**
- I may cancel or modify this PAC Agreement at any time, subject to providing the Company thirty (30) days notice in writing. To obtain a sample cancellation form or for more information on my right to cancel the PAC Agreement, I may contact my financial institution or visit [www.cdnpay.ca](http://www.cdnpay.ca) regarding Rule H1 – Pre-authorized debits (PADs).
- Any cancellation of this PAC Agreement will not affect my insurance contract(s) and/or contract(s) for financial services, so long as payment is provided by an alternate method.
- The Company will not assign this PAC Agreement without providing, any time prior to the next PAC, written notice to me of the assignment.**
- I have certain recourse rights if any PAC does not comply with this PAC Agreement. For example, I have the right to receive reimbursement for any PAC that is not authorized or is not consistent with this PAC Agreement. To obtain more information on my recourse rights, I should contact my financial institution or visit [www.cdnpay.ca](http://www.cdnpay.ca) regarding Rule H1 – Pre-authorized debits (PADs).

\*Business PAC means a PAC for the payment of goods or services related to a business or commercial activity of the payor.

### General information

Name of Policyowner(s): \_\_\_\_\_

Contract Number: \_\_\_\_\_

|  |                |
|--|----------------|
| <b>1 Do you already pay by PAC?</b><br><input type="checkbox"/> No → (Complete items 3 and 4 and sign.)<br><input type="checkbox"/> Yes → (Complete items 2 and 4 and sign.) | TO HEAD OFFICE |
|--|----------------|

|  |   |
|--|---|
| <b>2 Authorization number<sup>(1)</sup></b><br>_____ | <sup>(1)</sup> The authorized signatory(ies) must always be the same as the one(s) that authorized the original transaction for which the authorization number had been issued. |
|--|---|

**3 Banking Information – Attach specimen cheque; if a specimen cheque is attached, do not complete the banking information.**

Name of Financial Institution: \_\_\_\_\_

Name of Account holder(s): \_\_\_\_\_

Branch #      Institution #      Account #

1 This is the cheque number (do not write this number).

2 This is the branch number (5 digits).

3 This is the financial institution number (3 digits).

4 This is the account number. The format may vary from one financial institution to another. Indicate all numbers and only the numbers.

**4 Withdrawal Arrangement:** Variable      PAC category:  Personal     Business (If both boxes are left unchecked, the PAC category will be considered "Personal.")

Starting 

|   |   |   |
|---|---|---|
| D | M | Y |
|---|---|---|

Day of withdrawal:  Same as existing PAC      Amount of PAC:  Minimum premium for contract

Day: \_\_\_\_\_ (1 to 28)

**Signature** (For a joint account, all required signatories must sign this PAC Agreement. For a company, the PAC Agreement must be signed by the authorized signatory(ies) and accompanied by a copy of the company's resolution stipulating the authorized signatory(ies).)

Date: 

|   |   |   |
|---|---|---|
| D | M | Y |
|---|---|---|

      X \_\_\_\_\_  
Account holder's signature

Date: 

|   |   |   |
|---|---|---|
| D | M | Y |
|---|---|---|

      X \_\_\_\_\_  
Account holder's signature, if applicable

**Contact Information:**

**Vancouver:** Industrial Alliance Pacific Insurance and Financial Services Inc.  
 PFS-Life Administration      Telephone: 604 737-9384  
 2165 Broadway West      Fax: 604 739-0534  
 PO Box 5900      Email: [intouch@iapacific.com](mailto:intouch@iapacific.com)  
 Vancouver, BC V6B 5M6

# Broker Disclosure

**1. Application Information:**

- Name :
- Address :
- App Number : T.B.A
- Supplier : IAP - Alternative Whole Life

**2. Disclosure:**

a) I am contracted and am licensed to do business with the following companies in the following provinces:

|                |                    |                               |
|----------------|--------------------|-------------------------------|
| BMO Life       | IAP Life           | Transamerica Life             |
| Canada Life    | Manulife Financial | Unity Life                    |
| Desjardin Life | RBC Life           | Insurance Council of BC       |
| Empire Life    | Standard Life      | Insurance Council of Alberta  |
| Equitable Life | Sun Life           | Insurance Council of Manitoba |

- b) No product supplier or Managing General Agency (MGA) holds any interest or ownership in my business, nor do I hold an interest in any insurance company.
- c) I will be paid a sales commission, renewal commission or service commission by the company chosen.
- d) I may be eligible to receive educational upgrading as well as potential marketing allowances, bonuses or educational conferences supplied by the product supplier or MGA.
- e) I declare no conflict of interest in the product solution I am recommending, and that my overall recommendation takes into consideration and is based on my analysis and assessment of your financial and security needs.
- f) Should you require additional information about my qualifications or the nature of my business relationships, I would be pleased to assist you.
- g) In accordance with provincial legislation, I am not permitted to engage in any form of tied selling.

**3. Approval**

I acknowledge receipt of this Broker Disclosure document and approve that. I authorize the Arthur Rowland and Churchill Insurance Brokerage Svs and their suppliers to retain such for their records.

Proposed Insured

X \_\_\_\_\_

\_\_\_\_\_ Date

\_\_\_\_\_ City/Province