Serious Illness. Critical Coverage.

Affordable Critical Illness Insurance

Serious illness can have life-changing consequences — not only for your health, but also for your finances. Critical illness insurance provides the comfort and security of a tax-free, lump-sum payment with no restrictions on how it is spent.

It is an unfortunate fact – even with the best extended health and disability plans, a serious illness can end up costing you money.

Critical illness insurance is designed to give you some extra resources at a time when you need to focus on your health, not your finances. Underwritten by Industrial Alliance Insurance and Financial Services Inc., the plan provides coverage for 25 illnesses and includes several value added benefits at no additional cost.

For definitions of all covered conditions and the AdvanceCare Benefit, please visit **specialmarkets.ia.ca/critical-illness-definitions**

Additional benefits at no extra cost

Claims at TuGo
Should you choose to use private medical facilities, **Claims at** TuGo may help you make your money go considerably further than if you personally arrange medical treatment. You can find more information at tugo.com/tms. Note that utilization fees may apply.

AdvanceCare benefit *
Receive 10% of the total benefit amount for coronary angioplasty and several early stage cancers without affecting the benefit payment for a covered condition.

Multiple event coverage *
Claim multiple times for separate and unrelated covered conditions.

Cancer recurrence *
If you are diagnosed with cancer, while insured under this policy, and after 60 consecutive months of being cancer-free you are diagnosed with cancer again, the full benefit amount may be payable.

Coverage for 25 life-changing illnesses

- Aortic Surgery
- Aplastic Anemia
- Bacterial Meningitis
- Benign Brain Tumour
- Blindness
- Cancer
- Coma
- Coronary Artery Bypass Surgery
- Deafness
- Dementia including Alzheimer's Disease*
- Heart Attack
- Heart Valve Replacement or Repair
- Kidney Failure
- Loss of Independent Existence*
- Loss of Limbs
- Loss of Speech
- Major Organ Failure on Waiting List
- Major Organ Transplant
- Motor Neuron Disease
- Multiple Sclerosis
- Occupational HIV Infection
- Paralysis
- Parkinson's Disease and Specified Atypical Parkinsonian Disorders*
- Severe Burns
- Stroke

Protection for the entire family

Coping with a serious illness is one of the greatest challenges any family can face. Purchasing coverage for your spouse and dependent children gives you peace of mind knowing that you will have some extra financial resources to help your entire family through a difficult time.

You and your spouse can apply for up to $500,000 in coverage. And you can apply for up to $10,000 in coverage for your children. Children are covered for six children-specific conditions plus 22 of the adult covered conditions:

- Cerebral Palsy
- Down Syndrome
- Congenital Heart Disease
- Muscular Dystrophy
- Cystic Fibrosis
- Type 1 Diabetes

All your children are covered for one low premium rate. Children born after your initial purchase can be added to the plan without the need for medical underwriting. Simply complete a Request to Add a Child within 90 days of their birth. Dependent child coverage is only available if you are also insured under the plan.

* Not available to dependent children

Are there limitations or exclusions I should be aware of?

Yes, there are some important limitations and exclusions for you to be aware of before you apply for coverage:

- The insured person must survive for 30 days (90 days for paralysis, loss of independent existence or bacterial meningitis, 180 days for multiple sclerosis or loss of speech) after first being diagnosed for a benefit payment to be made.
- If the insured person is diagnosed with a benign brain tumour, cancer or early stage cancer within the first 90 days of coverage, or with multiple sclerosis or Parkinson's within the first year of coverage, a benefit will not be payable and the diagnosed condition will no longer be considered a covered condition for the insured.
- A diagnosis of benign brain tumour, multiple sclerosis or Parkinson's within the applicable limitation period will also result in any condition under MEC Group 3 no longer being payable (specialmarkets.ia.ca/mec).
- Any covered condition or AdvanceCare Benefit condition diagnosed prior to the effective date of coverage is excluded.
- No Cancer Recurrence Benefit will be paid if the first instance of cancer was diagnosed before the effective date of coverage under this policy.
- No benefit will be paid if the covered condition or AdvanceCare Benefit Condition results from: attempted suicide, alcohol or drug abuse, war or armed forces service, self-inflicted injury, taking poison or inhaling gas, or participation in a criminal act. For blindness, coma, deafness, loss of limbs, severe burns, paralysis or stroke, no benefit will be paid if the condition is a result of participating in hazardous sports or activities. There is also an exclusion for certain pilots.

What happens to my coverage if I am no longer an employee of this group?

Because this is group insurance, you must be an eligible employee to join the plan, and to maintain coverage for yourself and your family. However, conversion to a separate policy is available to you and your spouse before age 65, within 31 days of ceasing to be eligible. A maximum of $100,000 may be converted.

Here's how little monthly premiums cost

Monthly Premium per $25,000

Plus taxes where applicable. Rates are subject to annual review.

	MALE		FEMALE	
Age*	Non-Smoker**	Smoker	Non-Smoker**	Smoker
Under 25	$2.65	$3.80	$2.70	$3.70
25–29	$3.55	$5.95	$3.70	$6.10
30–34	$4.45	$8.00	$4.60	$8.80
35–39	$5.40	$10.45	$5.60	$10.95
40–44	$7.55	$16.10	$8.20	$15.95
45–49	$11.50	$26.90	$12.45	$24.85
50–54	$17.20	$44.75	$17.80	$38.15
55–59	$23.60	$66.95	$23.40	$58.10
60–64	$39.60	$108.75	$37.85	$81.95
65–69	$58.20	$165.75	$57.70	$127.30
70–74†	$115.95	$266.20	$82.50	$184.75
75	Coverage Terminates			

* Premiums are calculated each year, based on your age at January 1 and will increase as you enter a new age band.

** Non-smoker rates apply to individuals who, at the time of application, have not used tobacco, nicotine, or cannabis mixed with tobacco in any form whatsoever within the last 12 months and who have provided satisfactory evidence of insurability.

† For renewal only, last age to apply is 69.

For all eligible children

Benefit Amount	Monthly Premium
$5,000	$1.95
$10,000	$3.90

Who can apply?

Regular employees of an eligible municipal entity affiliated with the Policyholder who work at least 15 hours per week and who have completed their eligibility waiting period, if applicable, and their spouses.

Applicants must be under age 70 and residing in Canada.

Dependent children are also eligible to apply provided they are under age 21 (up to 24 if they are enrolled full-time at a post-secondary school) and the employee also applies for coverage.

Residents of Quebec under age 65 must be insured under a private drug plan in order to apply.

How do I apply?

Please complete an Application for Voluntary Critical Illness Insurance. Acceptance will be subject to the health and lifestyle information you provide.

Send your completed application to:
iA Special Markets
Industrial Alliance Insurance and Financial Services Inc.
400–988 Broadway W., PO Box 5900, Vancouver BC V6B 5H6

Questions? We're here to help.

Contact a Client Service Specialist at:
1.800.266.5667 (toll-free) **604.737.3802** (Vancouver)
specialmarkets@ia.ca
Monday to Friday 6:30 a.m. – 4:30 p.m. Pacific Time

Underwritten by:
Industrial Alliance Insurance & Financial Services Inc.
400–988 Broadway W PO Box 5900, Vancouver, BC V6B 5H6

FOR OFFICE USE ONLY

APPLICATION FOR VOLUNTARY GROUP INSURANCE

Please complete, print and sign.

POLICY INFORMATION

Name of Policyholder: Alberta Municipal Services Corporation

Group Policy Number: 100003919

EMPLOYEE INFORMATION MUST ALWAYS BE COMPLETED

Last Name | Given Name | Initials | Gender (◯ Male ◯ Female) | Date of Birth (dd-mmm-yyyy)

Municipality Name | Division No. | Date of Employment (dd/mmm/yyy)

Place of Birth | Occupation

Street Address | City | Prov. -- | Postal Code

Telephone (Home) | Telephone (◯ Work ◯ Cell) | Email

SPOUSE INFORMATION COMPLETE THIS SECTION WHEN APPLYING FOR SPOUSAL COVERAGE

Are you also an Employee of a municipality/organization that is a member of Alberta Municipalities? ◯ Yes ◯ No If "Yes", please complete a separate application.

What is your spousal status? ◯ Married ◯ Civil Union ◯ Common-Law, please provide date of cohabitation (dd-mmm-yyyy) _____

Last Name | Given Name | Initials | Gender (◯ Male ◯ Female) | Date of Birth (dd-mmm-yyyy)

Place of Birth | Occupation

INSURANCE INFORMATION SELECT INSURANCE APPLYING FOR

◯ **Employee Critical Illness Insurance**
(Units of $25,000 to $500,000 max.)
Total amount of insurance requested (include any existing amounts)

◯ **Spouse Critical Illness Insurance**
(Units of $25,000 to $500,000 max.)
Total amount of insurance requested (include any existing amounts)

◯ **Dependent Children Critical Illness Insurance***
(Units of $5,000 to $10,000 max. – Available only if the employee is insured or applying for Critical Illness Insurance)
Total amount of insurance requested (include any existing amounts)

*** If applying for Dependent Children Critical Illness Insurance, please complete a Supplemental Dependent Questionnaire # 4584**

iA Financial Group

HEALTH AND LIFESTYLE QUESTIONS MUST ALWAYS BE COMPLETED WHEN APPLYING

If you answer "Yes" to any question below (or "No" to question 8), please complete the Additional Details section below.

		Employee		Spouse	
		Yes	No	Yes	No
1)	**Employee:** Height: ◯ ft/in ◯ cm Weight: ◯ lbs ◯ kgs				
2)	**Spouse:** Height: ◯ ft/in ◯ cm Weight: ◯ lbs ◯ kgs				
3)	In the last 12 months, have you used, in any form whatsoever, tobacco, nicotine or cannabis mixed with tobacco?	◯	◯	◯	◯
4)	Have you flown as a pilot, student or crew member in the last two years or do you have any intention to do so?	◯	◯	◯	◯
5)	Have you engaged in or do you intend to participate in scuba diving, parachuting or other hazardous sport or activity?	◯	◯	◯	◯
6)	Do you intend to travel or reside outside Canada or the United States for more than a month?	◯	◯	◯	◯
7)	Have you had a request for life, disability or critical illness insurance declined, postponed, rated or modified in any way?	◯	◯	◯	◯
8)	Are you now actively engaged in your occupation on a full-time basis? If "No", please provide details including reason why you are not working on a full-time basis.	◯	◯	◯	◯
9)	Have you ever had or ever been treated for cancer, tumour, cyst, polyp or other growth, moles, anemia, blood disorder or any form of malignant disease? Any immune system abnormality including AIDS (Acquired Immune Deficiency Syndrome), positive HIV test, enlargement of lymph glands, unusual skin lesions, or unexplained infections?	◯	◯	◯	◯
10)	Have you ever had or have you ever been treated for chest pain, angina, heart attack, high blood pressure, abnormal ECG, stroke, paralysis, transient ischemic attack (TIA), elevated cholesterol, or other disorders of the heart or aorta, blood vessels or circulatory system? Diabetes, pancreatitis, thyroid or other endocrine disorder? Lung or other respiratory disease or disorder? Any disorder of the eyes (excluding near or far sightedness), ears, vocal chords or larynx including loss of speech?	◯	◯	◯	◯
11)	Have you ever been treated for or diagnosed with kidney, bladder, prostate (including an elevated PSA test result) or breast disorder (including cysts, lumps, biopsy or abnormal mammogram or ultrasound) or other genitourinary disorder, hepatitis B or C (including carrier), cirrhosis or other liver disorder, ulcerative colitis, Crohn's disease or other disorder of the gastrointestinal tract?	◯	◯	◯	◯
12)	Have you ever had or have you ever been treated for dizziness, seizures, epilepsy, tremor, paresthesia, loss of balance, numbness, multiple sclerosis, Alzheimer's disease, Parkinson's disease, amyotrophic lateral sclerosis (ALS) or any other neurological disorder? Stress, anxiety, depression or any other psychiatric disorder? Disease or disorder of muscles, ligaments, tendons, bones or joints including but not limited to arthritis, lupus in any form, amputation or deformity?	◯	◯	◯	◯
13)	Have you ever used marijuana, heroin, morphine, cocaine, LSD, barbiturates, amphetamines, or any other drug or narcotic, except as prescribed by your physician?	◯	◯	◯	◯
14)	a) Do you presently drink more than 12 alcoholic beverages per week? If "Yes", state number, kind and frequency consumed.	◯	◯	◯	◯
	b) Have you ever changed your pattern of drinking (increased or decreased), received advice or treatment for, or attended any rehabilitation program for alcohol or drug use?	◯	◯	◯	◯
15)	Have you any condition for which hospitalization, further testing, investigation or surgery has been advised, or which have not yet been done, or for which you are still awaiting results?	◯	◯	◯	◯
16)	Are you taking any prescribed medication? If "Yes", state name of medication and reason for use.	◯	◯	◯	◯
17)	Are you aware of any symptoms or complaints regarding your health for which you have not yet consulted a physician or received treatment?	◯	◯	◯	◯
18)	Have you been absent from work for more than seven consecutive days within the past year due to sickness or injury?	◯	◯	◯	◯
19)	Has there been a variation in your weight in the past year? If "Yes", please provide details including reason and number of pounds/kilograms gained or lost.	◯	◯	◯	◯
20)	Females only: Are you currently pregnant? If "Yes", please provide your estimated due date and advise of any complications with current or past pregnancies.	◯	◯	◯	◯
21)	During the past 10 years, have you consulted a physician, received treatment or been hospitalized, had surgery or any test **(other than routine checkup or minor injury)** for any disease, disorder or ailment not already mentioned?	◯	◯	◯	◯
22)	Have you ever received or claimed benefits or a pension for sickness, injury or impairment?	◯	◯	◯	◯
23)	Do you have any pending criminal offences, criminal convictions, had your driver's license suspended, or within the past 3 years been convicted of more than 3 traffic violations?	◯	◯	◯	◯

ADDITIONAL DETAILS IF YOU ANSWER "YES" TO ANY QUESTION OR "NO" TO QUESTION 8, PROVIDE DETAILS BELOW

Question Number	Name of person to be insured	Details (include dates, duration and names and addresses of all doctors, hospitals, etc.). If you require more space, please attach a separate sheet of paper, signed and dated.

FAMILY HISTORY QUESTION MUST ALWAYS BE COMPLETED WHEN APPLYING

Have any of your natural parents, brothers or sisters ever undergone bypass surgery or suffered from any of the following conditions: Heart attack, angina or any other heart condition, stroke, polycystic kidney disease, diabetes, cancer (if "Yes", specify type), Alzheimer's disease, Parkinson's disease, multiple sclerosis, amyotrophic lateral sclerosis (ALS), Huntington's disease, alcoholism, nervous or mental disorder, or any other hereditary disease?	Employee		Spouse	
	Yes	No	Yes	No
	◯	◯	◯	◯

If "Yes", please complete the following table. If you require more space, please attach a separate sheet of paper, signed and dated.

	Employee			Spouse		
	Condition	Age at Onset/ Diagnosis	Age at Death (if applicable)	Condition	Age at Onset/ Diagnosis	Age at Death (if applicable)
Father						
Mother						
Brothers						
Sisters						

PERSONAL PHYSICIAN INFORMATION MUST ALWAYS BE COMPLETED WHEN APPLYING

Employee's Personal Physician Information

Personal Physician's Name

Telephone

Street Address

City

Prov.

Postal Code

--

Date last consulted ANY Doctor (dd-mmm-yyyy)

Reason for consultation

Results (e.g. normal), diagnosis, treatment or medication prescribed

Spouse's Personal Physician Information

Personal Physician's Name

Telephone

Street Address

City

Prov.

Postal Code

--

Date last consulted ANY Doctor (dd-mmm-yyyy)

Reason for consultation

Results (e.g. normal), diagnosis, treatment or medication prescribed

DECLARATION AND AUTHORIZATION FORM MUST BE SIGNED IN INK

I acknowledge receipt of the Disclosure Notice (attached) describing the operation of the Medical Information Bureau. I authorize:

a) any health care professional as well as any other public or private health or social service establishment, any insurance company, the Medical Information Bureau, any insurance plan sponsor, any agent, broker or market intermediary, any third party administrator, any personal information agents or professional investigation agencies and any government agency, or other organization, institution or person that has any records or knowledge of me or my health, to give to Industrial Alliance Insurance and Financial Services Inc. (the "Company") or its reinsurers any such information for the purpose of the risk assessment, administration or investigation of a subsequent claim.

b) the Company or its reinsurers to release and exchange any personal information obtained to the above persons and organizations for the purposes of assessment of this application, the administration of any certificate issued and the investigation of any claim.

c) the Company to test and evaluate a specimen of my blood, urine or saliva for the purpose of assessing me as an insurance risk. This analysis includes testing for HIV infection.

d) the Company to release any abnormal test results to my personal physician.

I acknowledge that all correspondence relating to this application, including the requirement for additional medical information and the communication of any underwriting decision, will be directed to the applicant. If applying for dependent coverage, all communication will be directed to the employee.

I further acknowledge receipt of the Notice on Privacy and Confidentiality (attached) summarizing certain privacy practices regarding collection, use and disclosure of my personal information.

I agree to the use of my personal information for the purposes outlined in this application. I understand that my consent to the use of any information to offer me products and services is optional and that if I wish to discontinue such use I may call or write to the Company at the telephone number or address shown on this application.

I confirm that the foregoing answers, forming part of an application for group insurance to the Company are true, full, complete and correctly recorded, and together with any other forms signed by me in connection with this application form the basis for any certificate issued hereunder. I understand that any group insurance arising from this application may not be valid if there is any incorrect answer or misrepresentation in this application or if there is any change in my insurability between the date of this application and the effective date of coverage. I acknowledge that it is my responsibility to notify the Company of any change in my health or insurability. I agree that my insurance will not take effect until my properly completed application has been approved by the Company and the first month's premium has been paid.

I wish to participate in this insurance plan and, if my application is approved, I authorize the deduction of the appropriate premium from my salary.

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

X		X	
Employee Signature (must always sign)	Date (dd-mmm-yyyy)	**Spouse Signature** (if applying)	Date (dd-mmm-yyyy)

NOTICE ON PRIVACY & CONFIDENTIALITY PLEASE READ CAREFULLY AND RETAIN 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. (the "Company") employees, its reinsurers, third party administrators, agents or brokers of the Company, plan sponsors and any agents or brokers of such sponsors or other market intermediaries for the purposes of (a) sponsoring a plan for you, (b) marketing and administration of Company products or services, (c) assessment of risk (underwriting) and (d) investigation of claims (where applicable). **Your file will be kept in our 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: 400–988 West Broadway. P.O. Box 5900, Vancouver, BC V6B 5H6, Attention: Director, iA Special Markets. 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 online at ia.ca or alternatively, contact us at 1.800.266.5667 and request that a copy be faxed or mailed to you.

DISCLOSURE NOTICE - MEDICAL INFORMATION BUREAU PLEASE READ CAREFULLY AND RETAIN FOR YOUR RECORDS

Information regarding your insurability will be treated as confidential. Industrial Alliance Insurance and Financial Services Inc. (the "Company") and its reinsurers may, however, make a brief report thereon to the Medical Information Bureau (MIB), a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such company, MIB, upon request, will supply that company with the information it may have in its files.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction. The address of MIB's Information office is: Medical Information Bureau, 330 University Avenue, Toronto, Ontario, Canada M5G 1R7, telephone number (416) 597-0590.

The Company may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

SEND YOUR COMPLETED FORM TO

iA Special Markets
Industrial Alliance Insurance and Financial Services Inc.
400–988 Broadway W, PO Box 5900, Vancouver, BC V6B 5H6

QUESTIONS?

Contact a Client Service Specialist at:
1.800.266.5667 (toll-free)
604.737.3802 (Vancouver)
specialmarkets@ia.ca
Monday to Friday 6:30 a.m. - 4:30 p.m. Pacific Time