ALBERTA MEDICAL ASSOCIATION

GROUP ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE APPLICATION FORM

iA Financial Group

Please complete this form and mail the original to:

ADIUM Insurance Services Inc.
CMA Alberta House, 12230 106 Ave NW Edmonton AB T5N 3Z1

POLICYHOLDER INFORMATION

Name of Policyholder: **Alberta Medical Association**

Policy Number: 100004432

APPLICANT INFORMATION

Applicant's Last Name ______ Applicant's Given Name ______ Initials ______

Address ______ City ______ Province ______ Postal Code ______

Email Address ______

May the Policyholder correspond with the Applicant via email for the purpose of administering this application? ☐ Yes ☐ No

Applicant's Date of Birth ______ dd ______ mmm ______ yyyy

Amount of Insurance $ ______ (units of $50,000.00 to a maximum of $1,000,000.00)

Selected Plan ☐ Member Only ☐ Member and Family

NB: If you and your spouse are both eligible under the policy only one may elect the Family Plan with dependent children coverage only.

Applicant's Beneficiary ______ Relationship to Applicant ______ Age (if a minor) ______

NB: If your beneficiary is a minor, complete the Accidental Death & Dismemberment Beneficiary Designation form.

Quebec Residents: If you have named your spouse as your beneficiary, this designation will be automatically irrevocable. **If you do not wish your designation to be irrevocable, please check here: ☐ Revocable**

FAMILY PLAN INFORMATION COMPLETE ONLY IF YOU HAVE CHOSEN THE FAMILY PLAN

Spouse's Last Name ______ Spouse's Given Name ______ Initials ______

Spouse's Date of Birth ______ dd ______ mmm ______ yyyy

Family Plan Beneficiary: The beneficiary of all dependents' loss of life benefits will be the Applicant.

AUTHORIZATION FORM MUST BE SIGNED IN INK

I acknowledge that I have read the Notice on Privacy and Confidentiality summarizing certain privacy practices regarding collection, use and disclosure of my personal information. I understand that no insurance will be in effect until the insurance applied for has been approved by the Policyholder and payment has been made. I declare that the answers recorded above are, to the best of my knowledge and belief, full, complete, and true as of the date hereof.

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

X ______ **Signature of Applicant**

______ Date (dd-mmm-yyyy)

The terms and conditions governing the insurance are set out in the Master Policy which is on file with the Policyholder.

NOTICE ON PRIVACY AND 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: 2165 West Broadway. P.O. Box 5900, Vancouver, BC V6B 5H6, Attention: Director, 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 online at ia.ca or alternatively, contact us at 1.800.266.5667 and request that a copy be faxed or mailed to you.

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Alberta Medical Association	100004432

PREMIUM PAYMENTS MONTHLY OR ANNUAL PRE-AUTHORIZED PAYMENT (PAP)

If the Applicant wishes to have the applicable premium payment(s) collected directly by the Policyholder from the Applicant's bank account, complete the following section.

Check Desired Payment Frequency:

- ☐ Monthly (interest free)
- ☐ Annual (full payment for balance of calendar year and annually the first week of January thereafter)
- ☐ Please add payments to my existing pre-authorized payment plan

Please include a VOID cheque from the account to be debited OR complete the following:

Account Holder's Last Name ______ Account Holder's Given Name ______ Initials ______

Name and Address of Financial Institution (Street Number and Name) ______

Transit # ______ Institution # ______ Account # ______

AUTHORIZATION FORM MUST BE SIGNED IN INK

I/We confirm that all persons whose signatures are required to authorize bank withdrawals have signed below. I/We acknowledge that I/we have read the Terms and Conditions below.

X ______ **Signature of Account Holder** ______ Date (dd-mmm-yyyy)

X ______ **Signature of Account Holder** ______ Date (dd-mmm-yyyy)

TERMS AND CONDITIONS

You authorize the Policyholder to collect, depending on your selection, the monthly or annual premium (including applicable provincial tax) for this insurance via Pre-Authorized Debit (PAD) from the account indicated above. You acknowledge that the financial institution may treat any withdrawal pursuant to this authorization as a withdrawal for personal services. You acknowledge that the amount of the monthly or annual premium (including applicable provincial tax) collected through this agreement may vary. **You agree to waive the requirement for the Policyholder to notify you of any payments after the first payment whether or not the amount of the monthly or annual premium has changed.** You understand that if you selected the monthly payment option, the monthly premium is due on the first of each month; if you selected the annual payment option, the annual premium payment is due on the first of January each year. This agreement will be cancelled automatically if the Policyholder is unable to make a withdrawal from the account indicated above.

This authorization is to remain in effect until the Policyholder has received written notification from you of any change or termination. This notification must be received at the address above at least 10 business days before the next debit is scheduled. You may obtain a sample PAD cancellation form, or more information on your right to cancel a PAD Agreement, at your financial institution or by visiting www.cdnpay.ca.

The Policyholder may not assign this authorization to another company or person to permit them to debit the account indicated above for these payments (for example where there has been a change in control of the company) without providing at least 10 days prior written notice to you.

You have certain recourse rights if any debit does not comply with this agreement. For example, you have the right to receive reimbursement for any debit that is not authorized or not consistent with this PAD Agreement. To obtain more information on your recourse rights, contact your financial institution or visit www.cdnpay.ca.

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