

7. BANKING INFORMATION (Please attach a void cheque AND complete the banking information below.)

Financial institution name: _____

Name of the account owner(s): _____ and _____

Banking Information:

Branch No. (5 digits)	Financial Institution No. (3 digits)	Bank Account No.

8. AUTHORIZATION OF THE ACCOUNT OWNER FOR PRE-AUTHORIZED DEBITS (Please attach a void cheque.)

Yes, I authorize Industrial Alliance 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 here under mentioned.

I waive the right to receive pre-notification of an increase or decrease in the amount to be debited or a change in the date and/or frequency of these payments.

I agree that Industrial Alliance is not required to provide me with a written notice of a change in the pre-authorized debits (PAD) amount that is made as a result of my request. If a PAD is dishonoured for any reason such as, but not limited to, insufficient funds ("NSF"), stop payment or account closed, Industrial Alliance is authorized to resubmit the payment. **Any charges incurred by Industrial Alliance as a result of the dishonoured PAD will be added to the subsequent PAD.**

I may cancel or modify this PAD agreement at any time, subject to providing Industrial Alliance with thirty (30) days notice in writing. To obtain a cancellation form or for more information on my right to cancel the PAD agreement, I may contact my financial institution or visit www.cdnpay.ca regarding Rule H1: pre-authorized debits (PADs). Any cancellation of this PAD 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. **Industrial Alliance may not assign this PAD agreement without providing, any time prior to the next PAD, written notice to me of the assignment.**

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

Signature of account owner _____ Date

Y									
M									
D									

Signature of account owner (if applicable) _____ Date

Y									
M									
D									

9. DIRECT DEPOSIT REQUEST FOR HEALTH AND DENTAL BENEFITS (Please attach a void cheque.)

Yes, I am subscribing to direct deposit to have my health and dental claim reimbursements automatically deposited in my bank account, and to be informed by email when claims have been processed.

Email: _____ Work Home

Banking information: same as mentioned at section 7.

Banking information:

Branch No. (5 digits)	Financial Institution No. (3 digits)	Bank Account No.

10. TO CONTACT YOUR ADMINISTRATOR

For any question regarding the group plan, please contact:



275 Des Braves Blvd., Suite 310
Terrebonne, Quebec J6W 3H6
sgc@samsongroupeconseil.com

Telephone: 450 492-9812
Toll-free: 1 877 492-9812
Fax: 450 492-7099

PARTICIPANT CONFIRMATION AND AUTHORIZATION

I HEREBY APPLY for the benefits which I am or may become eligible for, subject to any waiver indicated, under the l'Ordre des CGA du Québec members 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 l'Ordre des CGA du Québec, Samson Groupe Conseil inc. and Industrial Alliance, its employees, agents, reinsurers and service providers for the purpose of underwriting, administration, claims processing and the enrolment of myself and my dependents in the l'Ordre des CGA du Québec members group insurance plan.

I AGREE that a photocopy of this Confirmation/Authorization shall be as valid as the original.

Participant's signature _____ Date

Y									
M									
D									

DISCLOSURE

At Industrial Alliance and at Samson Groupe Conseil inc., 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 Industrial Alliance and at Samson Groupe Conseil inc. offices.

You have the right to request access to your personal information and, if necessary, correct any inaccurate information. In order to do so, send a written request to the following: 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 Samson Groupe Conseil inc. and Industrial Alliance's employees, agents, reinsurers and service providers in the performance of their jobs, individuals to whom you have granted access, and persons authorized by law.

For the purposes of audits and administrative reporting, Industrial Alliance may release to l'Ordre des CGA du Québec statistical financial information without personal identifiers.