

TERMINATION REQUEST FORM

Specified coverage will terminate as per the terms of the group policy.

Name of Group/Policyholder	Group Policy Number	Division Number	Member/Employee ID
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

MEMBER/EMPLOYEE INFORMATION

Last Name	Given Name	Date of Birth
<input type="text"/>	<input type="text"/>	<input type="text"/>

YOUR CURRENT MAILING ADDRESS REQUIRED FOR TERMINATION CONFIRMATION AND REFUND OF PREMIUMS, IF APPLICABLE

Street Address	City	Prov.	Postal Code
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Telephone (Home)	Telephone (<input type="radio"/> Work <input type="radio"/> Cell)	Email	
<input type="text"/>	<input type="text"/>	<input type="text"/>	

TERMINATION SPECIFICATIONS

Option 1

Terminate all coverage under the above-mentioned group policy

Option 2

If you do not wish to terminate all coverage under the group policy, select below which benefit(s) you would like terminated:

Member/Employee

All member/employee benefits;

or select the applicable benefits

- Term Life
- Critical Illness
- Accidental Death & Dismemberment
- Other (please specify)

Spouse

All spouse benefits;

or select the applicable benefits

- Term Life
- Critical Illness
- Accidental Death & Dismemberment
- Other (please specify)

Dependent Children*

All dependent benefits;

or select the applicable benefits

- Term Life
- Critical Illness
- Other (please specify)

* Note if you are terminating the dependent coverage for only some of your dependent children, please specify their names listed on a separate piece of paper attached to this form, otherwise the termination will apply to all dependent children covered under the benefit.

Please provide the reason for terminating your coverage.

Reasons for Termination:

No longer eligible for coverage as of (date: dd-mmm-yyyy)

Service needs improvement No Longer need coverage Product does not meet my needs Cost Other

Tell us more:

AUTHORIZATION FORM MUST BE SIGNED IN INK

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

<p>X</p> <p>_____ Member/Employee Signature (must always sign)</p>	<p>_____ Date (dd-mmm-yyyy)</p>	<p>X</p> <p>_____ Spouse Signature (if applicable)</p>	<p>_____ Date (dd-mmm-yyyy)</p>
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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