InstaTerm

Data Collection Form – To be complete for *each* insured

This is not an application; do not submit.

The information in this document is only valid once uploaded into Assumption Life's electronic sales platform, Lia

Policy option: ☐ Individual policy ☐ Rider

This form is for: ☐ Proposed Insured 1 ☐ Proposed Insured 2 *(for InstaTerm or InstaTerm Deferred rider)*

A. PROPOSED INSURED INFORMATION

First Name	Address
Last Name	City
Previous Last Name	Province
Occupation	Postal Code
Name of Employer	Home Tel._ _ _-_ _ _-_ _ _ _ Work Tel._ _ _-_ _ _-_ _ _ _
Annual (Employment) Income	E-mail
Province of Birth	Date of Birth _ _/_ _ _/_ _ _ _ (DD MMM YYYY) (Example: 01/JAN/2014)
Country of Birth	Gender ☐ M ☐ F

Current residency status in Canada:
☐ Canadian citizen
☐ Permanent resident (landed immigrant)
☐ Other (specify) ____________________
If other, indicate date of status _ _/_ _ _/_ _ _ _ (DD MMM YYYY)

In the past twelve (12) months, have you used any substance or product containing tobacco, nicotine, or marijuana or used e-cigarettes?

Smoker: ☐ No ☐ Yes

B. INSURANCE REQUESTED

☐ InstaTerm ☐ InstaTerm Deferred $____________________

Coverage Amount ($50,000 to $150,000 for InstaTerm – $50,000 to $100,000 for InstaTerm Deferred)

Additional Benefit Riders

☐ Accidental Death - AD
(max. age 55)*: $__________________

☐ Child Insurance Benefit: ☐ $10,000 ☐ $20,000
(max. age of Proposed Insured is 60)

Accidental Fracture Plus (max. age of Proposed Insured is 69):

☐ Insured ☐ Insured and Spouse ☐ Insured and Children

☐ Insured, Children and Spouse

☐ 1 unit
☐ 2 units

** AD rider amount cannot be greater than the initial sum insured.*

Name of the Insured's spouse:____________________________________

Full name of Insured's children:

1. ____________________________________
2. ____________________________________
3. ____________________________________
4. ____________________________________
5. ____________________________________

C. PAYMENT METHOD *(Complete only on data collection form for **Proposed Insured 1**)*

☐ Annual ☐ Monthly PAD
☐ Semi- Annual
☐ Quarterly

Regular preauthorized debit (PAD) withdrawal day:
☐ Coïncides with day of application approval by Assumption Life
☐ On the______(1st to 28th) day of the month

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D. REPLACEMENT

Is the insurance requested intended to replace an existing individual life insurance? ☐ No ☐ Yes *

* If Yes, please ensure that you satisfy the Proposed Insured's province's disclosure requirements pertaining to the replacement of a life insurance policy. Moreover, if the original policy being replaced is with Assumption Life, a written notice or a ''policy service request'' signed by the owner of the original policy must be sent to Assumption Life in order to terminate the existing policy.

E. BENEFICIARY UPON DEATH OF THE PROPOSED INSURED *(Complete only on data collection form for **Proposed Insured 1 and 2**)*

	First Name and Last Name	Age	%	Beneficiary type *	Relationship with proposed Insured (in Quebec, relationship with the owner)
Primary	____________	____	____	☐ Irrevocable ☐ Revocable	____________
	____________	____	____	☐ Irrevocable ☐ Revocable	____________
	____________				____________
	____________				____________

If a % is indicated the total must equal 100 %.

Substitute *(Replace the primary beneficiary if he/she die before the proposed insured)*

	First Name and Last Name	Age	Relationship
	____________	____	____________
	____________	____	____________

If a % is indicated the total must equal 100 %.

Contingent *(Upon death of all primary and substitute beneficiaries)*

	First Name and Last Name	Age	%	Beneficiary type *	Relationship
	____________	____	____	☐ Irrevocable ☐ Revocable	____________
	____________	____	____	☐ Irrevocable ☐ Revocable	____________

If a % is indicated the total must equal 100 %.

Assign a Trustee		Relationship to Beneficiary
	____________	____________
	____________	____________

* In Quebec, the designation by the owner of a married or civil union spouse as beneficiary is irrevocable, unless otherwise stipulated. All other beneficiary designations are revocable. The designation of an irrevocable beneficiary limits your rights under the contract and his/her consent will be required for all future transactions including withdrawals and changes of beneficiary.

F. OWNER/PAYER INFORMATION *(Complete only on data collection form for **Proposed Insured 1**)*

Owner:	☐ Proposed Insured 1	☐ Proposed Insured 2	☐ Other or Body Corporate (complete below)		
Co-owner:	☐ Proposed Insured 1	☐ Proposed Insured 2	☐ Other (complete below)		
Payer:	☐ Proposed Insured 1	☐ Proposed Insured 2	☐ Owner	☐ Co-owner	☐ Other (complete below)

Banking Information *(If possible, please include a personal cheque marked "VOID")*

Bank Name

Bank Number | Branch number | ☐ Savings | ☐ Chequing

Account Number

Complete if owner is a Body Corporate *(corporation, partnership, etc.)*

Name of Body Corporate	
Registration Number	Name of Directors
Address	
City	
Province	Name of persons authorized to sign for the Body Corporate, with their title:
Postal Code	Name / Title
Telephone	Name / Title

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Complete if owner is Other

Check below if applicable and complete only first and last name.	Address
☐ See data form for WP on Owner named below.	City Province
First Name	Postal Code
Last Name	Home Telephone
Date of Birth _ _/_ _ _/_ _ _ _ DD MMM YYYY (Example 01/JAN/2014)	Work Telephone
	E-mail
Copy address: Proposed Insured ☐ 1 ☐ 2	Relationship to Proposed Insured

Complete if co-owner or payer is Other

Check below if applicable and complete only first and last name.	Address
☐ See data form for WP on Payer named below.	City Province
First Name	Postal Code
Last Name	Home Telephone
Date of Birth * _ _/_ _ _/_ _ _ _ DD MMM YYYY (Example 01/JAN/2014)	Work Telephone
	E-mail
Copy address: Proposed Insured ☐ 1 ☐ 2	Relationship to Proposed Insured *

**** These fields do not have to be completed for the payer.***

G. DECLARATION OF INSURABILITY

SECTION A – For InstaTerm and InstaTerm Deferred

1.	In the **last 90 days**, have you been hospitalized, admitted to a long-term care facility or nursing home, bedridden or confined to a chair?	☐ No ☐ Yes
2.	In the **past three (3) years**, have you had an amputation as a result of disease?	☐ No ☐ Yes
3.	In the **past three (3) years:**	
	a. Have you been diagnosed with or hospitalized for angina or a heart attack or undergone coronary angioplasty or coronary artery bypass surgery?	☐ No ☐ Yes
	b. Have you been diagnosed with or hospitalized for chronic kidney disease or undergone dialysis?	☐ No ☐ Yes
	c. Have you been diagnosed with leukemia or cancer (other than basal cell carcinoma)?	☐ No ☐ Yes
	d. Have you been diagnosed with or undergone surgery for an aneurysm?	☐ No ☐ Yes
4.	In the **past three (3) years**, have you been prescribed a new medication or required a change in dosage of your medication relating to: angina, heart attack, leukemia or cancer (other than basal cell carcinoma)?	☐ No ☐ Yes
5.	In the **past three (3) years**, have you been diagnosed with or hospitalized for:	
	a. Chronic obstructive pulmonary disease (COPD) or emphysema that required the administration of oxygen?	☐ No ☐ Yes
	b. Hepatitis B, hepatitis C, or cirrhosis of the liver?	☐ No ☐ Yes
	c. Diabetic coma or insulin shock?	☐ No ☐ Yes
	d. Cerebrovascular accident (stroke)?	☐ No ☐ Yes
	e. Congestive heart failure or cardiomyopathy?	☐ No ☐ Yes
6.	In the **past five (5) years** have you received a bone marrow transplant or an organ transplant (other than a corneal transplant) or were you advised that one was required?	☐ No ☐ Yes
7.	In the **past five (5) years** have you been diagnosed with, hospitalized for, or undergone treatments (including medication) for HIV, AIDS or AIDS-related complex?	☐ No ☐ Yes
8.	Have you ever been diagnosed with or treated for (including medication) amyotrophic lateral sclerosis (Lou Gehrig's disease), Alzheimer's disease or dementia?	☐ No ☐ Yes
9.	Have you been advised by a physician that you have an incurable terminal illness for which you have less than 12 months to live?	☐ No ☐ Yes
10.	Are you aware of any symptoms for which you have not yet consulted a physician and/or a specialist or received treatment, or for which you have consulted a physician without having received a diagnosis?	☐ No ☐ Yes

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11. Does your weight exceed the weight corresponding to your height in the following table? ☐ No ☐ Yes

Height		Weight		Height		Weight		Height		Weight	
Ft/in	cm	lb	kg	Ft/in	cm	lb	kg	Ft/in	cm	lb	kg
4'10"	147	188	85	5'6"	168	235	107	6'2"	188	286	130
4'11"	150	193	88	5'7"	170	240	109	6'3"	191	294	134
5'0"	152	199	90	5'8"	173	246	112	6'4"	193	301	137
5'1"	155	204	93	5'9"	175	254	115	6'5"	196	307	140
5'2"	157	212	96	5'10"	178	259	118	6'6"	198	315	143
5'3"	160	218	99	5'11"	180	265	120	6'7"	201	323	147
5'4"	163	223	101	6'0"	183	272	124	6'8"	203	329	150
5'5"	165	228	104	6'1"	185	280	127	6'9"	206	338	154

If you answered NO to all questions in Section A above, you qualify for InstaTerm Deferred. To qualify for InstaTerm, with immediate coverage, you must have answered NO to all questions in Section A above AND section B on the following page.

G. DECLARATION OF INSURABILITY

SECTION B – for InstaTerm

12. In the **past three (3) months**, have you required a new medication for high blood pressure or an increase in the dosage of any medication for high blood pressure? ☐ No ☐ Yes

13. Has your weight changed by more than 18.14 kg (40 lb) in the **past year** (other than pregnancy related)? ☐ No ☐ Yes

14. In the **past twelve (12) months**, due to depression, an emotional, a behavioral, psychological or nervous disorder, have you been hospitalized or did you require more than six (6) months off work or are you currently off work for any of these conditions? ☐ No ☐ Yes

15. In the **past two (2) years**, have you had an application for individual life insurance declined or postponed by a company other than Assumption Life? ☐ No ☐ Yes

16. In the **past three (3) years** have you required hospitalization for: transient ischemic attack (TIA or mini-stroke), chest pain, arrhythmia or diabetes? ☐ No ☐ Yes

17. In the **past five (5) years**, have you been diagnosed with or started treatment for convulsions, epilepsy, multiple sclerosis, heart disease, Parkinson's disease, muscular dystrophy, Huntington's disease or rheumatoid arthritis? ☐ No ☐ Yes

18. In the **past five (5) years**:

a. Have you been diagnosed with or hospitalized for angina or a heart attack or undergone coronary angioplasty or coronary artery bypass surgery? ☐ No ☐ Yes

b. Have you been diagnosed with or hospitalized for chronic kidney disease or undergone dialysis? ☐ No ☐ Yes

c. Have you been diagnosed with leukemia or cancer (other than basal cell carcinoma)? ☐ No ☐ Yes

d. Have you been diagnosed with or undergone surgery for an aneurysm? ☐ No ☐ Yes

19. In the **past five (5) years**, have you been prescribed a new medication or required a change in dosage in your medication relating to: angina, heart attack, leukemia or cancer (other than basal cell carcinoma)? ☐ No ☐ Yes

20. In the **past five (5) years**, have you been diagnosed with or hospitalized for:

a. Hepatitis B, hepatitis C, or cirrhosis of the liver? ☐ No ☐ Yes

b. Cerebrovascular accident (stroke)? ☐ No ☐ Yes

21. In the **past five (5) years**, have you required the administration of oxygen for any chronic respiratory condition? ☐ No ☐ Yes

22. In the **past five (5) years,** have you used any drugs except as prescribed by a physician and other than marijuana? ☐ No ☐ Yes

23. In the **past five (5) years**, due to alcohol abuse, have you been advised by a health professional to reduce your consumption of alcohol or have you received advice or treatment for alcohol abuse? ☐ No ☐ Yes

24. Are you currently engaged or do you intend to engage in any hazardous sports or activities or make aerial flights other than as a passenger, a commercial pilot, or a crew member of a commercial flight? (Intend is defined as something that someone expects or plans to do in the next 12 months.) ☐ No ☐ Yes

25. Have you any intention of travelling outside North America, the Caribbean or Western Europe for more than six weeks or more than twice per year? (Intention is defined as something that someone expects or plans to do in the next 12 months.) ☐ No ☐ Yes

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26. Do you have two (2) or more biological family members (father, mother, brother, sister), living or deceased, who were diagnosed before age 60 with the same condition among the following: diabetes, cancer, stroke, heart trouble, mental disorder that required hospitalization or who committed suicide? ☐ No ☐ Yes

27. Do you have a biological family member (father, mother, brother, sister), living or deceased, who was diagnosed before age 60 with any of the following conditions: Huntington's disease, polycystic kidney disease or any hereditary disease other than those listed in question 26? ☐ No ☐ Yes

If you answered NO to all questions in sections A and B, you qualify for the InstaTerm life insurance.

H. CHILD'S INSURANCE BENEFIT (CIB)

Complete only if checked in the "INSURANCE REQUESTED" section.

List each natural or adopted child of Proposed Insured who is single and dependent upon this person for support:

	First and Last Name	Date of Birth day/month/year	Age	Sex	Height ft/in or m/cm	Weight lb-oz or kg-g
(a)						
(b)						
(c)						
(d)						
(e)						

1. Were any of the children to be insured born prematurely or with an abnormality or disease? ☐ No ☐ Yes
2. Have any of the children to be insured been hospitalized or undergone any surgery? ☐ No ☐ Yes
3. Are any of the children to be insured taking medication, following a special diet or undergoing treatment for any condition? ☐ No ☐ Yes
4. Has any insurance on the children to be insured been refused, rated or issued with modifications? ☐ No ☐ Yes
5. Is this insurance intended to replace any other life insurance on any of the children to be insured? ☐ No ☐ Yes
6. Has any life insurance application been submitted to any other company within the past 12 months? ☐ No ☐ Yes

I. SPECIAL INSTRUCTIONS *(Complete only on data collection form for **Proposed Insured 1**)*

☐ Date of issue coincides with the day the application is approved by Assumption Life except if approved on the 29th, 30th or 31st, in which case the date of issue shall be on the 28th day of the month.

☐ Date of issue requested (DD/MMM/YYYY): _____ /_____ /______ (Example: 01/JAN/2014)

- Administrative restrictions may apply.

IMPORTANT – Message to representative

Please ensure that you have

- Provided and explained to the client an Advisor Disclosure Statement explaining your method of compensation and other financial benefits, the names of the insurance companies you represent as well as any conflict of interest.
- Duly verified the date of birth of all Proposed Insureds.
- Explained the questions contained on this form to all Proposed Insureds and Owners.

____
Name of representative (agent/broker) – Please print

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Notes

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