No Medical Insurance Data Collection Form

Data Collection Form - Complete this form for *each* insured

This is not an application. Do not submit.

The information in this document is only valid once uploaded into the Assumption Life e-commerce process.

Policy option: ☐ Individual policy ☐ Rider

This form is for:

☐ Proposed Insured 1 ☐ Proposed Insured 2

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	Email
Province of Birth	Date of Birth _ _/ _ _ _/_ _ _ _ (DD MMM YYYY) (Example: 01/JAN/2011)
Country of Birth	Gender ☐ M ☐ F
Present 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 mixed with nicotine or used e-cigarettes?* Smoker: ☐ No ☐ Yes

B. INSURANCE REQUESTED

No Medical Insurance - Immediate ☐ Term ☐ Whole Life

Existing coverage of all products under the Non-Medical Insurance category * (if applicable) _____ $

Sum insured requested +_____$

Total insurance coverage (maximum allowed : $250,000) = _____$

Please complete medical questionnaire 1 – 17.

*No Medical Term – Immediate; No Medical Term – Deferred; No Medical Whole Life – Immediate; No Medical Whole Life – Deferred; Golden Protection; Golden Protection Deferred; Golden Protection Plus; Total Protection; InstaTerm: InstaTerm Deferred.

Please note: if existing amount of coverage is not correctly specified, the sum insured requested may be reduced.

No Medical Insurance – Deferred ☐ Term ☐ Whole Life

Existing coverage of all products under the Non-Medical Insurance Category * (if applicable) _____ $

Sum insured requested + _____ $

Total insurance coverage (maximum allowed $150,000) = _____ $

Please complete medical questionnaire 1 – 8.

Please note: If existing amount of coverage is not correctly specified, the sum insured requested may be reduced.

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Additional Benefit Riders:

☐ Accidental Death – AD
(max. age of proposed insured is 55)* : $_____

Accidental Fracture Plus
(max. age of proposed insured is 69) :
☐ Insured ☐ Insured and Spouse ☐ Insured and Child
☐ Insured, Child and Spouse

☐ 1 unit
☐ 2 units

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

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

Name of the Insured's spouse:_____

Complete name of the 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

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)*

_____	___		
_____	___		_____
			_____

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

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

_____	___	____	☐ Irrevocable ☐ Revocable	_____
_____	___	____	☐ Irrevocable ☐ Revocable	_____

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

Assign a Trustee (optional)	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.

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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

Address

City

Province

Postal Code

Telephone

Names of Directors

Names of persons authorized to sign for the Body Corporate with their title:

Name Title

Name Title

Complete if owner is Other

Check below if applicable and complete only first name and last name.

☐ See data form for WP on Owner named afterward.

First Name

Last Name

Date of Birth _ _ / _ _ _ /_ _ _ _
DD MMM YYYY (Example 01/JAN/2011)

Copy address : Proposed Insured ☐ 1 ☐ 2

Address

City Province

Postal Code

Home Telephone

Work Telephone

E-mail

Relationship with Proposed Insured

Complete if co-owner or payer is Other

Check below if applicable and complete only first name and last name.

☐ See data form for WP on Payer named afterward.

First Name

Last Name

Date of Birth ** _ _ / _ _ _ /_ _ _ _
DD MMM YYYY (Example 01/JAN/2011)

Copy address : Proposed Insured ☐ 1 ☐ 2

Address

City Province

Postal Code

Home Telephone

Work Telephone

E-mail

Relationship with Proposed Insured **

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

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G. DECLARATION OF INSURABILITY

Questions 1-8 : No Medical Whole Life – Deferred **and** No Medical Term - Deferred

Questions 1-17 : No Medical Whole Life – Immediate **and** No Medical Term - Immediate

	Proposed Insured
1. In the past ninety (90) days, have you resided, on a temporary or permanent basis, in a long-term care facility or nursing facility or been hospitalized (admitted to a hospital), bedridden, or confined to a chair?	☐ No ☐ Yes
2. In the **past three (3) years**: (a) Have you had an amputation as a result of disease? (b) Have you been diagnosed with or hospitalized for chronic kidney disease or undergone dialysis? (c) Have you been diagnosed with or undergone surgery for an aneurysm? (d) Have you been diagnosed with, hospitalized for, or received radiation therapy for leukemia or cancer (other than basal cell carcinoma)? (e) Have you been diagnosed with or hospitalized for angina or a heart attack or undergone coronary angioplasty (with or without a stent insertion) or coronary artery bypass surgery? (f) Have you been prescribed a new medication or required a change in dosage in your medication relating to angina, a heart attack, leukemia, or cancer (other than basal cell carcinoma)?	☐ No ☐ Yes
3. 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? (b) Hepatitis B, hepatitis C, or cirrhosis of the liver? (c) Diabetic coma or hypoglycemic coma? (d) Cerebrovascular accident (stroke)? (e) Congestive heart failure or cardiomyopathy?	☐ No ☐ Yes
4. In the **past five (5) years**: (a) Have you received a bone marrow transplant or an organ transplant (other than a corneal transplant) or were you advised that one was required? (b) Have you been diagnosed with, hospitalized for, or undergone treatments (including medication) for cystic fibrosis, HIV, AIDS, or AIDS-related complex?	☐ No ☐ Yes
5. 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
6. Have you been advised by a physician that you have an incurable terminal illness for which you have less than twelve (12) months to live?	☐ No ☐ Yes
7. Are you aware of any signs or symptoms for which you have not yet consulted a physician and/or a medical specialist or received treatment, or for which you have consulted a physician and/or medical specialist without having received a diagnosis?	☐ No ☐ Yes

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

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

9. 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
10. In the **past twelve (12) months**: (a) Has your weight changed by more than 18.14 kg (40 lbs) (other than pregnancy related)? (b) Have you been hospitalized for, did you require more than six (6) months off work for, or are you currently off work for any of the following conditions: depression, attempted suicide, attention-deficit disorder, attention-deficit hyperactivity disorder, burnout, chronic anxiety, chronic fatigue, eating disorders, schizophrenia, nervous breakdown, an emotional, a behavioral, psychological or nervous disorder?	☐ No ☐ Yes
11. 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
12. In the past three (3) years, have you required hospitalization for: transient ischemic attack (TIA or mini-stroke), heart murmur, chest pain, arrhythmia, asthma, chronic bronchitis, pulmonary sarcoidosis, tuberculosis, or diabetes?	☐ No ☐ Yes

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13. In the **past five (5) years**: (a) Have you been diagnosed with or started treatment for convulsions, epilepsy, multiple sclerosis, heart disease, Parkinson's disease, muscular dystrophy, Huntington's disease, rheumatoid arthritis, or paralysis? (b) Have you been diagnosed with or hospitalized for chronic kidney disease or undergone dialysis? (c) Have you been diagnosed with or undergone surgery for an aneurysm? (d) Have you been diagnosed with, hospitalized for, or received radiation therapy for leukemia or cancer (other than basal cell carcinoma)? (e) Have you been diagnosed with or hospitalized for angina or a heart attack or undergone coronary angioplasty (with or without a stent insertion) or coronary artery bypass surgery? (f) Have you been prescribed a new medication or required a change in dosage in your medication relating to angina, a heart attack, leukemia, or cancer (other than basal cell carcinoma)? (g) Have you been diagnosed with or hospitalized for hemophilia?	☐ No ☐ Yes
14. In the **past five (5) years**: (a) Have you been diagnosed with or hospitalized for: hepatitis B, hepatitis C, cirrhosis of the liver, Crohn's disease, pancreatitis, ulcer or ulcerative colitis? (b) Have you been diagnosed with or hospitalized for a cerebrovascular accident (stroke)? (c) Have you required the administration of oxygen for any chronic respiratory condition? (d) Have you used any drugs except as prescribed by a physician and other than marijuana? (e) Due to alcohol or drug abuse, have you been advised by a health professional to reduce your consumption of alcohol or drugs or have you received advice or treatment for alcohol or drug abuse? (f) Have you been charged with an alcohol-related or a drug-related driving offence or refused a breathalyzer?	☐ No ☐ Yes
15. In the **next twelve (12) months**, do you expect or plan to: (a) 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 or do you currently do so? (b) Travel outside North America, the Caribbean, or Western Europe for more than six (6) weeks or more than twice per year?	☐ No ☐ Yes
16. Do you have: (a) Diabetes **and** have been diagnosed with two (2) or more of the following diabetes complications: proteinuria (protein in the urine), neuropathy (numbness or weakness of the extremities), peripheral vascular disease (a circulation disorder), or retinopathy (eye disorder)? (b) Any medical condition for which you are followed by a medical specialist at least every six (6) months **and** for which you require either treatment or medication, or regular testing at least every six (6) months? (Medical specialist does not include a general practitioner.)	☐ No ☐ Yes
17. Biological family history: (a) 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: type 1 diabetes, cancer, stroke, heart trouble, mental disorder that required hospitalization or who committed suicide? (b) 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 17 (a)?	☐ No ☐ Yes

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H. 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 where the date of issue shall be on the 28th day of the month.

☐ Date of issue requested (DD/MMM/YYYY): _____ /_____ /_____ (Example: 01/JAN/2011)

- 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 Insured and Owners**.**

_____

Name of representative (agent/broker) – Please print

Notes

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