LIA WORKSHEET
FOR UNDERWRITTEN PRODUCTS

COMPLETE FOR EACH INSURED

INSURED #____

Assumption Life

PRODUCT SELECTION

PERMANENT INSURANCE	TERM INSURANCE
ESSENTIAL WHOLE LIFE ☐ Life pay ☐ 20-pay ☐ Pay to 65 **Policy option** ☐ Individual ☐ Joint first-to-die ☐ Joint last-to-die **Sum Insured** (Min. $10,000 Max. $4,000,000) $_____	**FLEXTERM (LEVEL TERM)** ☐ 10 yrs ☐ 15 yrs ☐ 20 yrs ☐ 25 yrs ☐ 30 yrs ☐ 35 yrs **Policy option** ☐ Individual ☐ Joint first-to-die **Sum Insured** (Min. $50,000 – Max. $4,000,000) $_____
PARPLUS (PARTICIPATING) ☐ Life pay ☐ 20-pay **Policy option** ☐ Individual ☐ Joint first-to-die **Sum Insured** (Min. $5,000 – Max. $4,000,000) $_____ **Dividend Option** ☐ Cash ☐ Premium reduction ☐ Accumulation ☐ Paid up additions ☐ Enhanced 15-year guarantee	**FLEXOPTIONS (DECREASING TERM)** ☐ 15 yrs ☐ 20 yrs ☐ 25 yrs **Policy option** ☐ Individual ☐ Joint first-to-die **Sum Insured** (Min. $50,000 – Max. $4,000,000) $_____

GENERAL INFORMATION

First Name:	Last Name:	Previous Last Name:
Occupation	Name of Employer:	Annual (Employment) Income:

Province of Birth:

Country of Birth:

Date of Birth: _____ (DD / MM / YYYY)

Gender: ☐ M ☐ F

Present residency status in Canada:

☐ Canadian citizen

☐ Permanent resident (landed immigrant)

☐ Other (specify)_____

If other, indicate date of status: _____ (DD / MM / YYYY)

Address: _____

P.O. Box | No. & Street | Apt. No. | City | Province | Postal Code

Telephone #: Home _____ Work _____

Email: _____

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

6241-00A-SEP18

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.

ADDITIONAL BENEFIT RIDERS

PERMANENT INSURANCE

Additional Benefit Riders for Essential Whole Life and ParPlus:

☐ DI based on loans (Loan repayment option) $_____ per month (min. $300, max. $3,500 not exceeding 1.5% of the sum insured)

☐ DI based on employment income (Income replacement option) $_____ per month (min. $300, max. $3,500 not exceeding 1.5% of the sum insured or 75% of the annual employment income divided by 12)

☐ Critical illness rider–Sum Insured (Min. $10,000. – Max. $25,000) $_____

☐ Accidental Death & Dismemberment (AD&D) **: $_____

☐ Child Insurance Benefit: ☐ $10,000 ☐ $20,000

☐ Waiver of premium upon disability (WP) ***

☐ Waiver of premium upon death (WPD) ***

☐ Accidental Fracture Plus: ☐ Insured ☐ Insured and Spouse ☐ Insured and Child ☐ Insured, Child and Spouse ☐ 1 unit ☐ 2 units	Name of the Insured's spouse:	
	Complete name of the Insured's children:	
	1.	4.
	2.	5.
	3.	6.

TEMPORARY INSURANCE

Additional Benefit Riders for FlexTerm and FlexOptions:

☐ DI based on loans (Loan repayment option) $_____ per month (min. $300, max. $3,500 not exceeding 1.5% of the sum insured)

☐ DI based on employment income (Income replacement option) $_____ per month (min. $300, max. $3,500 not exceeding 1.5% of the sum insured or 75% of the annual employment income divided by 12)

☐ Critical illness rider–Sum Insured (Min. $10,000. – Max. $25,000) $_____

☐ Child Insurance Benefit (only available on FlexTerm): ☐ $10,000 ☐ $20,000

☐ Waiver of premium upon disability (WP) ***

☐ Waiver of premium upon death (WPD) ***

☐ Accidental Fracture Plus: ☐ Insured ☐ Insured and Spouse ☐ Insured and Child ☐ Insured, Child and Spouse ☐ 1 unit ☐ 2 units	Name of the Insured's spouse:	
	Complete name of the Insured's children:	
	1.	4.
	2.	5.
	3.	6.

*** AD&D Rider amount cannot be greater than the initial sum insured. AD&D is not available on joint policy.*
**** If WP/WPD is for owner or payer, please use a separate form.*

Available life riders other than the insured	Underwritten product selected			
	ESSENTIAL WHOLE LIFE	PARPLUS	FLEXTERM	FLEXOPTIONS
Essential Whole Life	Yes (max. 5)	No	No	No
No Medical Insurance - Whole Life	Yes (max. 2)	No	No	No
No Medical Insurance - Term	Yes (max. 2)	No	Yes (max. 2)	No
Golden Protection	Yes (max. 2)	No	No	No
Total Protection	Yes (max. 2)	No	No	No
FlexTerm	Yes (max. 5)	Yes (max. 5)	Yes (max. 5)	No
Youth Plus	Yes (max. 5)	Yes (max. 5)	Yes (max. 5)	No

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.*

FAMILY DOCTOR

Does the Proposed Insured have a family doctor? ☐ No ☐ Yes

☐ Family Doctor information not available at this time, to be provided at a later date

Family Doctor Name (Optional): _____

Family Doctor Address (Optional): _____

PAYMENT METHOD (Complete only on worksheet for Proposed Insured 1)

☐ Monthly (PAD)
☐ Annual (PAD)
☐ Annual
☐ 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

Has the payer been advised that by choosing a specific PAD date, it could result in two premium withdrawals within the first 30 days following the policy being put in force? ☐ No ☐ Yes

BENEFICIARY UPON DEATH OF THE PROPOSED INSURED

(Complete only on worksheet 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	
				☐ Irrevocable ☐ Revocable	
				☐ Irrevocable ☐ Revocable	
Substitute (Replace the primary beneficiary if he/she dies before the proposed insured)					
Contingent (Upon death of all primary and substitute beneficiaries)				☐ Irrevocable ☐ Revocable	
				☐ Irrevocable ☐ Revocable	
Optional					Relationship to Beneficiary
Assign a Trustee					

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

***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.*

OWNER/PAYER INFORMATION (Complete only on worksheet 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)
Indicate occupation			Social Insurance Number |___|___|___|___|___|___|___|___|___|___|		

☐ Birth Certificate ☐ Driver's License ☐ Passport ☐ Other (Specify) _____

Reference Number _____ Place of Issue (Province/Country) _____

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 OTHER / PAYER (IF DIFFERENT)

Check box if applicable and complete only first name and last name.	☐ See data form for WP on Owner named afterward.
First Name:	Date of Birth: _____ DD / MM / YYYY
Last Name:	

Address: _____
P.O. Box No. & Street Apt. No. City Province Postal Code

Telephone: Home _____ Work _____

Email: _____

Copy address: Proposed Insured ☐ 1 ☐ 2	Relationship with Proposed Insured

COMPLETE IF OWNER IS A BODY CORPORATE (CORPORATION, PARTNERSHIP, ETC.)

Name of Body Corporate:

Names of Directors	
Name	Name
Name	Name

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

Registration Number:

Address: _____
P.O. Box No. & Street Apt. No. City Province Postal Code

Téléphone #: _____

TRANSACTION ON BEHALF OF A THIRD PARTY (ONLY NEEDED FOR PARPLUS AND ESSENTIAL WHOLE LIFE)			
Have the owner(s) received money or instructions from anyone to purchase this life insurance? ☐ Yes ☐ No If yes, will the owner(s) have to give a portion of the cash surrender value upon policy's termination? ☐ Yes ☐ No			
Verification of owner and co-owner by means of an original document			
Owner (indicated above)		**Owner** (indicated above)	
SIN:		**SIN:**	
Type of Identity:		Type of Identity:	
Reference Number:		Reference Number:	
Place of Issue - Province:	Country:	Place of Issue - Province:	Country:

NOTES

DECLARATION OF INSURABILITY		NO	YES
1.	In the past five (5) years, have you applied for life insurance, critical illness insurance, disability insurance or reinstatement that has been declined, postponed, or modified (with higher premiums or exclusion)?		
2.	In the past ten (10) years, have you been tested for (other than routine tests showing negative results), received treatments for, or had any known indication of:		
	a. Cancer or tumor?		
	b. Convulsions, epilepsy, recurrent and severe headaches, paralysis, stroke, multiple sclerosis, Parkinson's disease, muscular dystrophy, Huntington's disease, Alzheimer's disease, dementia or any brain or neurological disorder, chronic fatigue, anxiety, depression, suicidal thoughts, attempted suicide, or other mental or nervous disorder?		
	c. Heart murmur, high blood pressure, palpitations, chest pains, heart disease or any other disorder of the heart, blood vessels or blood, including abnormal cholesterol levels?		
	d. Sleep apnea, respiratory or lung disorder, disorder of the stomach, liver, pancreas or intestines, including hepatitis B or C, or chronic diarrhea?		
	e. Disorder of the kidneys, ureter, bladder (other than an uncomplicated urinary tract infection), breast, prostate, genital or reproductive organs, including any sexually transmitted infections?		
	f. Disorder of the muscles, bones, back, neck, or joints, including fibromyalgia and arthritis, disorder of the eyes (other than corrective lenses), or disorder of the skin (other than acne or eczema)?		
	g. Diabetes, disorder of the glands (other than controlled hypothyroidism) or lymph nodes, or other unexplained infections?		
	h. AIDS (acquired immune deficiency syndrome), ARC (AIDS-related complex), AIDS virus antibody, or any other immunological disorder?		
3.	Are you aware of any signs or 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 and/or a specialist without having received a diagnosis?		
4.	In the past five (5) years, have you been convicted of impaired driving? If YES, complete and attach the Driving Record Questionnaire (4018).		
5.	In the past five (5) years, have you been convicted of a crime or violation of any law or are you currently accused of a crime or violation of any law for which a verdict has not yet been rendered? If YES, complete and attach the Criminal Activity Questionnaire (5337).		
6.	In the past five (5) years, have you used any drugs (including but not limited to marijuana, cocaine, LSD, amphetamines, hallucinogens, or unprescribed narcotics) or have you received advice or treatment for alcohol or drug abuse? If YES, complete and attach the appropriate questionnaire: Drug (3887), Alcohol (3876).		
7.	In the past five (5) years, have you been hospitalized, received treatments or been advised to receive treatment for any illness or disorder, other than discomfort, minor surgery or pregnancy?		
8.	In the past two (2) years, have you received more than three (3) tickets for moving violations? If YES, complete and attach the Driving Record Questionnaire (4018).		
9.	In the past two (2) years, have you engaged in any hazardous sports or activities or made aerial flights other than as a passenger or do you intend to engage in such sports, activities or flights? If YES, complete and attach the appropriate questionnaire: Scuba Diving (3908), Hazardous Sports and Activities (4885) or Aviation (3880).		
10.	Have you resided outside Canada in the past twelve (12) months or do you expect or plan to travel outside North America, the Caribbean, or Western Europe in the next twelve (12) months? If YES, specify the country, date, duration and, if applicable, purpose of travel or complete and attach the Foreign Travel and Residency Questionnaire (3893).		
11.	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?		
12.	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 11?		
13.	Has your weight changed by more than 9.08 kg (20 lbs) in the past year? If YES, state your current height and weight, your weight a year ago, the loss or gain and the reason.		

DECLARATION OF INSURABILITY (continued)												NO	YES
14.	Does your weight exceed the weight corresponding to your height in the following table?												
Height		**Weight**		**Height**		**Weight**		**Height**		**Weight**			
Ft/in	**cm**	**lb**	**kg**	**Ft/in**	**cm**	**lb**	**kg**	**Ft/in**	**cm**	**lb**	**kg**		
4' 10"	147	158	72	5' 6"	168	205	93	6' 2"	188	256	116		
4' 11"	150	163	74	5' 7"	170	210	95	6' 3"	191	264	120		
5' 0"	152	169	77	5' 8"	173	216	98	6' 4"	193	271	123		
5' 1"	155	174	79	5' 9"	175	224	102	6' 5"	196	277	126		
5' 2"	157	182	83	5' 10"	178	229	104	6' 6"	198	285	129		
5' 3"	160	188	85	5' 11"	180	235	107	6' 7"	201	293	133		
5' 4"	163	193	88	6' 0"	183	242	110	6' 8"	203	299	136		
5' 5"	165	198	90	6' 1"	185	250	114	6' 9"	206	308	140		
15.	Do you have any life insurance in force exceeding twenty (20) times your annual salary?												

RIDERS (Questions below must be answered if one of the following additional benefit riders is chosen.)	NO	YES
WAIVER OF PREMIUM UPON DISABILITY The waiver of premium upon disability is not renewable and terminates on the first of the following: on the expiry date of the policy's first term; on the rider anniversary nearest to the Insured's 60th birthday. The owner cannot be a Body Corporate (corporation, partnership, etc.). ☐ I have read the above statement and confirm that the Owner understands the terms and conditions.		
In the **past three (3) years**, have you:		
a. Been absent from work due to injury or illness for more than thirty (30) consecutive days?		
b. Applied for or received a disability benefit or compensation due to injury, illness or disability?		
c. Consulted or received any treatment from a physiotherapist, massage therapist, chiropractor or acupuncturist?		
DI BASED ON LOAN OR DI BASED ON EMPLOYMENT INCOME Answering "yes" to one of the following first two questions makes the Proposed Insured ineligible for disability income rider.		
Are you currently unemployed?		
By adding the number of hours worked in the past **eight (8) months**, have you been working on average fewer than twenty (20) hours per week?		
In the past **three (3) years**, have you:		
a. Been absent from work due to injury or illness for more than thirty (30) consecutive days?		
b. Applied for or received a disability benefit or compensation due to injury, illness or disability?		
c. Consulted or received any treatment from a physiotherapist, massage therapist, chiropractor or acupuncturist?		

FOR ALL "YES" ANSWERS (for declaration of insurability section)

For all "Yes" answers, please give full details including name of the Proposed Insured, question number and name of physician and hospital involved.

Name of the Proposed Insured	Question Number	Name of Physician	Hospital

CHILD INSURANCE BENEFIT (CIB) **Not available for FlexOptions

Complete only if checked in the "ADDITIONAL BENEFIT RIDER" 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.					

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

FOR ALL "YES" ANSWERS (for CHILD INSURANCE BENEFIT section)

For all "Yes" answers, please give full details including name of child, question number and name of physician and hospital involved.

Name fo Child	Question Number	Name of Physician	Hospital

SPECIAL INSTRUCTIONS (Complete only on worksheet 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/2018)

- No conditional temporary life insurance is applicable if the requested date of issue is in the future.
- 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 _____

QUESTIONS TO OBTAIN THE CONDITIONAL TEMPORARY INSURANCE AGREEMENT

ONLY FOR FLEXOPTIONS, FLEXTERM, YOUTH PLUS, ESSENTIAL WHOLE LIFE, PARPLUS, PARPLUS JUNIOR, CRITICAL PROTECTION AND CRITICAL ILLNESS RIDER

The questions featured inside the brackets below must be answered in order to qualify for the appropriate conditional temporary insurance.

		Proposed Insured 1		Proposed Insured 2		Proposed Insured 3	
		NO	YES	NO	YES	NO	YES
CI & Life / Life	a. In the last ten (10) years, have you been diagnosed with, received treatment for or had any indication or sign of: stroke, heart disease, tumor or cancer, HIV infection or AIDS?						
CI & Life / Life	b. Have you ever had an application for life insurance declined, cancelled, modified (with higher\premiums or an exclusion) or postponed?						
CI & Life / Life	c. In the last three (3) months, have you been advised to undergo surgery or diagnostic testing or investigation that has not yet been completed (for a reason other than dental problems, pregnancy or childbirth)?						
CI & Life / Life	d. Are you currently hospitalized or, in the last three (3) months, have you been admitted or advised to be admitted to a medical facility (except for childbirth)?						
CI & Life / CI	e. Have you ever been diagnosed with, received treatment for or had any indication or sign of: cystic fibrosis, disease or disorder of the heart or blood vessels, chest pain, mini-stroke, stroke, tumor or cancer, diabetes, chronic liver, lung or kidney disease, HIV infection or AIDS, paralysis or blindness?						
CI & Life / CI	f. Have you ever had an application for life insurance or critical illness insurance declined, cancelled, modified (with higher premiums or an exclusion) or postponed?						

Eligibility for conditional temporary insurance is subject to the following terms and conditions:

- If the proposed insured requested life insurance only: answer questions (a) to (d) above.
  If the answer to one of these questions is YES or if one of these questions is not answered, the proposed insured will not qualify for conditional temporary life insurance.
- If the proposed insured requested life insurance and the critical illness rider: answer questions (a) to (f) above.
  If the answer to one of these questions is YES or if one of these questions is not answered, the proposed insured will not qualify for conditional temporary life insurance or conditional temporary critical illness insurance. However, if the answer to questions (a) to (d) is NO and if the answer to questions (e) and/or (f) is YES, the proposed insured will qualify for conditional temporary life insurance but will not qualify for conditional temporary critical illness insurance.
- If the proposed insured requested Critical Protection critical illness insurance: answer questions (c) to (f) above.
  If the answer to one of these questions is YES or if one of these questions is not answered, the proposed insured will not qualify for conditional temporary critical illness insurance.