DATA COLLECTION FORM FOR **SIMPLIFIED ISSUE PRODUCTS**

Assumption Life

6666-00A-APR22

The purpose of this document is to collect information about the proposed insured for input into the Lia electronic application.
This document is not an application—do not submit it.

1 PROPOSED INSURED

Name

First	Last	Maiden Name (if applicable)

Address

No.	Street	Apartment No.	PO Box

City/Town	Province	Postal code

Date of Birth

Province of Birth:

Country of Birth:

Date of Birth: ____________ DD / MM / YYYY

Age: ________ (at nearest birthday)

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

Social Insurance Number |___|___|___|___|___|___|___|___|___|

Contact Information

Home phone	Work phone	Email

Smoker Status

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? ☐ No ☐ Yes
If the answer is "No", the premium class will be non smoker. If the answer is "Yes", the premium class will be smoker.

**Please verify the date of birth of the Proposed Insured by means of an original identification document.*

2 OWNER

Owner Information

Owner is: ☐ Insured ☐ Other (Body Corporate or other than Proposed Insured named above), complete below

First	Last	Relationship to proposed insured

No.	Street	Apartment No.	PO Box

City/Town	Province	Postal code

Date of Birth: ____________ DD / MM / YYYY

Gender: ☐ M ☐ F

Social Insurance Number |___|___|___|___|___|___|___|___|___|

Home phone	Work phone	Email

Body Corporate

If the Owner is a Body Corporate (corporation, partners, etc.), complete below

Name of Body Corporate	Registration number	Relationship to proposed insured

Name of Body Corporate's directors:		
	1.	2.
	3.	4.

Indicate the names of the persons authorized to sign for the Body Corporate with their title:		
	Name	Title
	Name	Title

3 DECLARATION OF TAX RESIDENCY

Canadian financial institutions are required under Part XVIII and Part XIX of the Income Tax Act to collect the information you provide on this form to determine if they have to report your financial account to the Canada Revenue Agency (CRA). The CRA may share that information with the government of a foreign jurisdiction that you are resident of for tax purposes, or a citizen of in the case of the United States. You can ask your financial institution if it reported your financial account to the CRA and what information was provided.

As of January 1st, 2021, financial institutions must obtain the Self-Certification of Residence for tax purposes to issue the policy.

For a an individual, please complete form RC518 available in our Advisor Corner document center.
For a corporation, please complete form RC519 and provide with the application.

Select all that applies:

☐ **Owner is a tax resident of Canada**

☐ **Owner is a tax resident or a citizen of the United States**

Taxpayer identification number (TIN) from the United States:	
If the owner does not have a TIN from the United States, please note that he/she will have to apply for a TIN within the next 90 days following the submission of the application. **Once the TIN is received, does the owner agree to provide the TIN to Assumption Life within 15 days of its receipt?** *If the owner does not agree to follow the CRA requirements, they cannot continue with the application process.*	☐ Yes ☐ No

☐ **Owner is a tax resident of a jurisdiction other than Canada or the United States.**

Jurisdiction:	Taxpayer identification number (TIN):

If owner does not have a TIN for a specific jurisdiction, select reason:

☐ Application is in progress/Will apply within 90 days ☐ Jurisdiction of tax residence does not issue TINs ☐ Other reason

For this form, "Other reason" is enough. However, they will still have to tell your financial institution the specific reason.

4 BENEFICIARY DESIGNATION

	First name	Last name	Relationship to the Proposed Insured (In Quebec, relationship to Owner)	Age	%*	
Primary Beneficiary	First name	Last name	Relationship to the Proposed Insured (In Quebec, relationship to Owner)	Age	%*	Revocable ☐ Irrevocable ☐
	First name	Last name	Relationship to the Proposed Insured (In Quebec, relationship to Owner)	Age	%*	Revocable ☐ Irrevocable ☐
Contigent Beneficiary (Upon death of all primary and substitute beneficiaries)	First name	Last name	Relationship to the Proposed Insured (In Quebec, relationship to Owner)	Age	%*	Revocable ☐ Irrevocable ☐
	First name	Last name	Relationship to the Proposed Insured (In Quebec, relationship to Owner)	Age	%*	Revocable ☐ Irrevocable ☐

Assign a trustee (Optional)	If the Beneficiary is a minor, please designate a Trustee:	Relationship of the Trustee to the Beneficiary:

* If a % is not stated, insurance proceeds will be payable in equal shares to the beneficiaries who survive the Proposed Insured. If a % is stated and a substitute beneficiary has been designated, insurance proceeds will be payable to the substitute beneficiary in the event that the primary beneficiary dies before the Proposed Insured. If no primary or substitute beneficiary survives the Proposed Insured, the insurance proceeds will be divided equally among all designated contingent beneficiaries who survive the Proposed Insured. You can designate substitute beneficiaries by submitting the "Change of beneficiary form – Substitute beneficiary" available in the Document Center.

In Quebec, the designation of the Owner's married or civil union spouse as beneficiary is irrevocable, unless otherwise stipulated.

Revocable or Irrevocable: Unless otherwise stipulated or not permitted by law, any beneficiary designation is revocable. If a beneficiary is named irrevocably, please note that his/her consent is required for any request that may affect his/her rights, including a change of beneficiary.

The policy does not confer any rights to the substitute beneficiary prior to the death of the primary beneficiary.

The policy does not confer any rights to the contingent beneficiary prior to the death of all primary and substitute beneficiaries.

5 INSURANCE REPLACEMENT

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

If "Yes", is the original insurance policy being replaced an Assumption Life policy? ☐ 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.

6 PRODUCT TRIAGE

This guide will help you quickly determine which product best suits your client's health condition. If your client does not have any of the conditions listed below, they are most likely eligible for our Platinum Protection product.

DOES YOUR CLIENT HAVE A MEDICAL CONDITION? Start with the left column and work your way to the right until your client is able to meet the conditions listed. The column selected will determine the most appropriate product.

Once the product is selected, complete the corresponding Declaration of Insurability. Please note that each product has its own set of questions.

Medical Conditions	Platinum Protection	Golden Protection Elite	Golden Protection	Silver Protection	Bronze Protection [1]
Alcohol or drug abuse	✓ If over 3 years	✓ If over 3 years	✓ If over 2 years	✓ If over 12 months	✓
Angina or heart attack	✓ If over 5 years	✓ If over 5 years	✓ If over 3 years	✓ If over 2 years	✓
Currently bedridden, hospitalized, or awaiting a diagnosis	✗	✗	✗	✗	✓
Bipolar disorder, schizophrenia, or psychosis	✓ If over 5 years	✓ If over 3 years	✓	✓	✓
Cancer or leukemia	✓ If over 5 years	✓ If over 5 years	✓ If over 3 years	✓ If over 2 years	✓
Chronic kidney disease	✓ If over 5 years	✓ If over 5 years	✓ If over 3 years	✓ If over 2 years	✓
Congestive heart failure or cardiomyopathy	✓ If over 10 years	✓ If over 10 years	✓ If over 5 years	✓ If over 5 years	✓
Oxygen administration for a chronic respiratory disorder	✓ If over 10 years	✓ If over 10 years	✓ If over 10 years	✓	✓
Crohn's disease	✓ If over 5 years	✓ If over 3 years	✓	✓	✓
Coronary angioplasty or bypass surgery	✓ If over 5 years	✓ If over 5 years	✓ If over 3 years	✓ If over 2 years	✓
Diabetes with 1 or more conditions[2]	✗	✓ If over 5 years	✓ If over 3 years	✓	✓
Epilepsy, Convulsions or Parkinson's	✓ If over 5 years	✓ If over 3 years	✓	✓	✓
Hepatitis B, Hepatitis C, Cirrhosis of the liver	✓ If over 10 years	✓ If over 5 years	✓ If over 3 years	✓	✓
High blood pressure (new medication or increased dosage)	✓ If over 3 months	✓	✓	✓	✓
HIV, AIDS	✗	✗	✗	✗	✓
Heart murmur or arrhythmia	✓ If over 5 years	✓ If over 3 years	✓	✓	✓
Biological family member diagnosed with Huntington's disease (applies to insured age 50 and under only)	✗	✗	✗	✗	✓
Used prescribed or non-prescribed marijuana products more than 6 times per week	✓ If over 3 years	✓ If over 3 years	✓ If over 2 years	✓	✓
Multiple sclerosis	✓ If over 5 years	✓ If over 3 years	✓	✓	✓
Obesity	✓ Weight table	✓ Weight table	✓ Weight table	✓ Weight table	✓
Organ transplant	✓ If over 10 years	✓ If over 10 years	✓ If over 5 years	✓ If over 5 years	✓
Hospitalized or treated with oral Prednisone for a respiratory disorder	✓ If over 2 years	✓ If over 2 years	✓ If over 12 months	✓	✓
Stroke	✓ If over 5 years	✓ If over 5 years	✓ If over 3 years	✓ If over 2 years	✓
Transient Ischemic Attack (TIA or mini stroke)	✓ If over 5 years	✓ If over 3 years	✓	✓	✓
Non Medical Conditions	**Platinum Protection**	**Golden Protection Elite**	**Golden Protection**	**Silver Protection**	**Bronze Protection[1]**
Committed a criminal act	✓ If over 3 years	✓ If over 3 years	✓ If over 2 years	✓	✓
Driver's license suspended or revoked due to an infraction	✗	✗	✓	✓	✓
Driving offence related to alcohol or drugs or refused a breathalyser (accused or charged)	✓ If over 3 years	✓ If over 3 years	✓ If over 2 years	✓	✓
Drug use (other than prescribed by a physician)	✓ If over 3 years	✓ If over 3 years	✓ If over 2 years	✓	✓
Hazardous sports or private aviation	✓ Next 12 months	✓ Next 12 months	✓	✓	✓
Travel outside North America, Western Europe or Caribbean (excluding Haiti) in the next 12 months	✓ If less than 6 weeks	✓ If less than 12 weeks	✓	✓	✓

[1] *Bronze Protection is a guaranteed issue product and does not have a declaration of insurability. Proceed to section 8 "Product Selection" to continue.*

[2] *The conditions include: Heart attack, Angina, Cerebrovascular accident (stroke), Peripheral vascular disease, Gangrene, Amputation and Hypoglycemic coma.*

7 DECLARATION OF INSURABILITY

DECLARATION OF INSURABILITY FOR PLATINUM PROTECTION. ALL 19 QUESTIONS MUST BE ANSWERED "NO".

1. Does your weight exceed the weight corresponding to your height in the following table?
You must obtain the height and weight information of the applicant for Lia, Height ______ Weight ______

☐ 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	192	87	5' 6"	168	247	112	6' 2"	188	310	141
4' 11"	150	198	90	5' 7"	170	254	115	6' 3"	191	318	144
5' 0"	152	205	93	5' 8"	173	262	119	6' 4"	193	326	148
5' 1"	155	212	96	5' 9"	175	270	122	6' 5"	196	334	151
5' 2"	157	219	99	5' 10"	178	278	126	6' 6"	198	342	155
5' 3"	160	226	103	5' 11"	180	286	130	6' 7"	201	350	159
5' 4"	163	233	106	6' 0"	183	294	133	6' 8"	203	358	162
5' 5"	165	240	109	6' 1"	185	302	137	6' 9"	206	366	166

2. In the past twelve (12) months, have you lost more than 10% of your current body weight (other than due to pregnancy, intentional dieting or exercise)? ☐ No ☐ Yes

3. Are you currently:
(a) Admitted to a hospital?
(b) Residing or are you on a waiting list to reside in a long-term care facility, nursing home, skilled nursing facility or any other facility requiring care of a skilled staff?
☐ No ☐ Yes

4. Are you aware of any signs, symptoms, or any abnormal diagnostic test for which:
(a) You have not yet consulted a physician?
(b) You are currently being investigated?
(c) You have a pending consultation with a medical specialist? (Medical specialist does not include a general practitioner and pending consultation does not include a routine follow-up.)
(d) You have consulted with medical specialist without having received a diagnosis?
(e) You are currently awaiting for a surgery (other than day surgery/outpatient surgery)?
☐ No ☐ Yes

5. Have you ever:
(a) Been diagnosed with, hospitalized for, or undergone treatment (including medication) for cystic fibrosis, HIV, AIDS, or AIDS-related complex?
(b) Been diagnosed with or undergone treatment (including medication) for muscular dystrophy, Huntington's disease, amyotrophic lateral sclerosis (Lou Gehrig's disease), Alzheimer's disease, or dementia?
(c) Been advised by a physician that you have a terminal illness for which you are currently receiving Palliative or Hospice care or have discussed this type of care with a health professional?
☐ No ☐ Yes

6. **Question for insured age 50 or under ONLY** - Do you have a biological family member (father, mother, brother, sister), who was diagnosed with Huntington's disease or polycystic kidney disease, and for which you have not been investigated for these diseases? ☐ No ☐ Yes

7. In the past ten (10) years, have you:
(a) Received a bone marrow transplant or an organ transplant (other than a corneal transplant) or were you advised that one was required?
(b) Been diagnosed with or hospitalized for congestive heart failure or cardiomyopathy?
☐ No ☐ Yes

8. In the past five (5) years, have you been diagnosed with or hospitalized for:
(a) Chronic kidney disease or polycystic kidney disease (PKD) or undergone dialysis?
(b) Angina or a heart attack or undergone coronary angioplasty (with or without a stent insertion) or coronary artery bypass surgery?
(c) Cerebrovascular accident (stroke)?
☐ No ☐ Yes

9. In the past five (5) years, have you been diagnosed with, hospitalized for, or undergone treatment (including medication) for leukemia or cancer (other than basal cell carcinoma)? ☐ No ☐ Yes

10. Have you ever been diagnosed with diabetes (other than gestational diabetes) **and** ever had any of the following conditions:
(a) Heart attack?
(b) Angina?
(c) Cerebrovascular accident (stroke)?
(d) Peripheral vascular disease?
(e) Gangrene?
(f) Amputation?
(g) Hypoglycemic coma?
☐ No ☐ Yes

11. In the past ten (10) years, have you required the administration of oxygen for a chronic respiratory disorder (other than sleep apnea)? ☐ No ☐ Yes

12. In the past two (2) years, have you been:
(a) Hospitalized for any respiratory disorder?
(b) Treated with oral Prednisone or other oral corticosteroid for any respiratory disorder?
☐ No ☐ Yes

DECLARATION OF INSURABILITY FOR **PLATINUM PROTECTION (CONTINUED)**

13. In the past ten (10) years, have you been diagnosed with or hospitalized for:
    (a) Hepatitis B or C?
    (b) Cirrhosis of the liver?
    (c) Chronic pancreatitis?
    (d) Two (2) or more episodes of acute pancreatitis?

☐ No ☐ Yes

14. In the past five (5) years, have you been diagnosed with, hospitalized for, or undergone treatment (including medication) for any of the following conditions:
    (a) Convulsions, epilepsy, transient ischemic attack (TIA or mini-stroke), a spinal cord or brain tumor?
    (b) Bipolar disorder, schizophrenia, or psychosis?
    (c) Multiple sclerosis or Parkinson's disease?
    (d) Rheumatoid arthritis or paralysis?
    (e) Heart murmur or arrhythmia?
    (f) Crohn's disease or ulcerative colitis?
    (g) Glomerulonephritis, scleroderma or Systemic Lupus Erythematosus (SLE)?

☐ No ☐ Yes

15. Is your driver's license currently suspended or revoked as a result of any driving infractions?

☐ No ☐ Yes

16. In the past three (3) years, have you:
    (a) Used narcotics, barbiturates or steroids (other than prescribed by a physician)?
    (b) Used any unprescribed drugs (other than marijuana products or over the counter medications), including but not limited to cocaine, LSD, amphetamines, hallucinogens?
    (c) Used any prescribed or non-prescribed marijuana products more than 6 times per week?
    (d) Been advised by a health professional to discontinue your consumption of alcohol or drugs, or have you received advice or undergone treatment (including medication) for alcohol or drug abuse?
    (e) Been accused or charged with an alcohol-related or a drug-related driving offence or refused a breathalyzer?
    (f) Been incarcerated, 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?

☐ No ☐ Yes

17. 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

18. In the next twelve (12) months, do you expect or plan to travel outside North America, the Caribbean (excluding Haiti), or Western Europe for more than six (6) weeks?

☐ No ☐ Yes

19. In the next twelve (12) months, do you expect or plan to engage in any hazardous sports or activities, or aerial flights other than as a passenger, commercial pilot, or crew member of a commercial flight?

☐ No ☐ Yes

DECLARATION OF INSURABILITY FOR **GOLDEN PROTECTION ELITE.** ALL 18 QUESTIONS MUST BE ANSWERED "NO".

1. Does your weight exceed the weight corresponding to your height in the following table?
   You must obtain the height and weight information of the applicant for Lia, Height ______ Weight ______

Height		Weight		Height		Weight		Height		Weight	
Ft/in	cm	lb	kg	Ft/in	cm	lb	kg	Ft/in	cm	lb	kg
4' 10"	147	192	87	5' 6"	168	247	112	6' 2"	188	310	141
4' 11"	150	198	90	5' 7"	170	254	115	6' 3"	191	318	144
5' 0"	152	205	93	5' 8"	173	262	119	6' 4"	193	326	148
5' 1"	155	212	96	5' 9"	175	270	122	6' 5"	196	334	151
5' 2"	157	219	99	5' 10"	178	278	126	6' 6"	198	342	155
5' 3"	160	226	103	5' 11"	180	286	130	6' 7"	201	350	159
5' 4"	163	233	106	6' 0"	183	294	133	6' 8"	203	358	162
5' 5"	165	240	109	6' 1"	185	302	137	6' 9"	206	366	166

☐ No ☐ Yes

2. In the past twelve (12) months, have you lost more than 10% of your current body weight (other than due to pregnancy, intentional dieting or exercise)?

☐ No ☐ Yes

3. Are you currently:
   (a) Admitted to a hospital?
   (b) Residing or are you on a waiting list to reside in a long-term care facility, nursing home, skilled nursing facility or any other facility requiring care of a skilled staff?

☐ No ☐ Yes

4. Are you aware of any signs, symptoms, or any abnormal diagnostic test for which:
   (a) You have not yet consulted a physician?
   (b) You are currently being investigated?
   (c) You have a pending consultation with a medical specialist? (Medical specialist does not include a general practitioner and pending consultation does not include a routine follow-up.)
   (d) You have consulted with medical specialist without having received a diagnosis?
   (e) You are currently awaiting for a surgery (other than day surgery/outpatient surgery)?

☐ No ☐ Yes

DECLARATION OF INSURABILITY FOR **GOLDEN PROTECTION ELITE (CONTINUED)**

Question	Answer
5. Have you ever: (a) Been diagnosed with, hospitalized for, or undergone treatment (including medication) for cystic fibrosis, HIV, AIDS, or AIDS-related complex? (b) Been diagnosed with or undergone treatment (including medication) for muscular dystrophy, Huntington's disease, amyotrophic lateral sclerosis (Lou Gehrig's disease), Alzheimer's disease, or dementia? (c) Been advised by a physician that you have a terminal illness for which you are currently receiving Palliative or Hospice care or have discussed this type of care with a health professional?	☐ No ☐ Yes
6. **Question for insured age 50 or under ONLY** - Do you have a biological family member (father, mother, brother, sister), who was diagnosed with Huntington's disease or polycystic kidney disease, and for which you have not been investigated for these diseases?	☐ No ☐ Yes
7. In the past ten (10) years, have you: (a) Received a bone marrow transplant or an organ transplant (other than a corneal transplant) or were you advised that one was required? (b) Been diagnosed with or hospitalized for congestive heart failure or cardiomyopathy?	☐ No ☐ Yes
8. In the past five (5) years, have you been diagnosed with or hospitalized for: (a) Chronic kidney disease or polycystic kidney disease (PKD) or undergone dialysis? (b) Angina or a heart attack or undergone coronary angioplasty (with or without a stent insertion) or coronary artery bypass surgery? (c) Cerebrovascular accident (stroke)?	☐ No ☐ Yes
9. In the past five (5) years, have you been diagnosed with, hospitalized for, or undergone treatment (including medication) for leukemia or cancer (other than basal cell carcinoma)?	☐ No ☐ Yes
10. Have you ever been diagnosed with diabetes (other than gestational diabetes) **and** had any of the following conditions in the past five (5) years: (a) Heart attack? (b) Angina? (c) Cerebrovascular accident (stroke)? (d) Peripheral vascular disease? (e) Gangrene? (f) Amputation? (g) Hypoglycemic coma?	☐ No ☐ Yes
11. In the past ten (10) years, have you required the administration of oxygen for a chronic respiratory disorder (other than sleep apnea)?	☐ No ☐ Yes
12. In the past two (2) years, have you been: (a) Hospitalized for any respiratory disorder? (b) Treated with oral Prednisone or other oral corticosteroid for any respiratory disorder?	☐ No ☐ Yes
13. In the past five (5) years, have you been diagnosed with or hospitalized for: (a) Hepatitis B or C? (b) Cirrhosis of the liver? (c) Chronic pancreatitis? (d) Two (2) or more episodes of acute pancreatitis?	☐ No ☐ Yes
14. In the past three (3) years, have you been diagnosed with, hospitalized for, or undergone treatment (including medication) for any of the following conditions: (a) Convulsions, epilepsy, transient ischemic attack (TIA or mini-stroke), a spinal cord or brain tumor? (b) Bipolar disorder, schizophrenia, or psychosis? (c) Multiple sclerosis or Parkinson's disease? (d) Rheumatoid arthritis or paralysis? (e) Heart murmur or arrhythmia? (f) Crohn's disease or ulcerative colitis? (g) Glomerulonephritis, scleroderma or Systemic Lupus Erythematosus (SLE)?	☐ No ☐ Yes
15. Is your driver's license currently suspended or revoked as a result of any driving infractions?	☐ No ☐ Yes
16. In the past three (3) years, have you: (a) Used narcotics, barbiturates or steroids (other than prescribed by a physician)? (b) Used any unprescribed drugs (other than marijuana products or over the counter medications), including but not limited to cocaine, LSD, amphetamines, hallucinogens? (c) Used any prescribed or non-prescribed marijuana products more than 6 times per week? (d) Been advised by a health professional to discontinue your consumption of alcohol or drugs, or have you received advice or undergone treatment (including medication) for alcohol or drug abuse? (e) Been accused or charged with an alcohol-related or a drug-related driving offence or refused a breathalyzer? (f) Been incarcerated, 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?	☐ No ☐ Yes
17. In the next twelve (12) months, do you expect or plan to travel outside North America, the Caribbean (excluding Haiti), or Western Europe for more than twelve (12) weeks?	☐ No ☐ Yes
18. In the next twelve (12) months, do you expect or plan to engage in any hazardous sports or activities, or aerial flights other than as a passenger, commercial pilot, or crew member of a commercial flight?	☐ No ☐ Yes

DECLARATION OF INSURABILITY FOR **GOLDEN PROTECTION.** ALL 13 QUESTIONS MUST BE ANSWERED "NO".

1. Does your weight exceed the weight corresponding to your height in the following table?
You must obtain the height and weight information of the applicant for Lia, Height ______ Weight ______

Height		Weight		Height		Weight		Height		Weight	
Ft/in	cm	lb	kg	Ft/in	cm	lb	kg	Ft/in	cm	lb	kg
4' 10"	147	206	93	5' 6"	168	264	120	6' 2"	188	330	150
4' 11"	150	213	97	5' 7"	170	272	123	6' 3"	191	339	154
5' 0"	152	220	100	5' 8"	173	280	127	6' 4"	193	348	158
5' 1"	155	227	103	5' 9"	175	288	131	6' 5"	196	357	162
5' 2"	157	234	106	5' 10"	178	296	134	6' 6"	198	366	166
5' 3"	160	241	109	5' 11"	180	304	138	6' 7"	201	375	170
5' 4"	163	248	112	6' 0"	183	312	142	6' 8"	203	384	174
5' 5"	165	256	116	6' 1"	185	321	146	6' 9"	206	393	178

☐ No ☐ Yes

2. In the past twelve (12) months, have you lost more than 10% of your current body weight (other than due to pregnancy, intentional dieting or exercise)? ☐ No ☐ Yes

3. Are you currently:
(a) Admitted to a hospital?
(b) Residing or are you on a waiting list to reside in a long-term care facility, nursing home, skilled nursing facility or any other facility requiring care of a skilled staff?
☐ No ☐ Yes

4. Are you aware of any signs, symptoms, or any abnormal diagnostic test for which:
(a) You have not yet consulted a physician?
(b) You are currently being investigated?
(c) You have a pending consultation with a medical specialist? (Medical specialist does not include a general practitioner and pending consultation does not include a routine follow-up.)
(d) You have consulted with medical specialist without having received a diagnosis?
(e) You are currently awaiting for a surgery (other than day surgery/outpatient surgery)?
☐ No ☐ Yes

5. Have you ever:
(a) Been diagnosed with, hospitalized for, or undergone treatment (including medication) for cystic fibrosis, HIV, AIDS, or AIDS-related complex?
(b) Been diagnosed with or undergone treatment (including medication) for muscular dystrophy, Huntington's disease, amyotrophic lateral sclerosis (Lou Gehrig's disease), Alzheimer's disease, or dementia?
(c) Been advised by a physician that you have a terminal illness for which you are currently receiving Palliative or Hospice care or have discussed this type of care with a health professional?
☐ No ☐ Yes

6. In the past five (5) years, have you:
(a) Received a bone marrow transplant or an organ transplant (other than a corneal transplant) or were you advised that one was required?
(b) Been diagnosed with or hospitalized for congestive heart failure or cardiomyopathy?
☐ No ☐ Yes

7. In the past three (3) years, have you been diagnosed with or hospitalized for:
(a) Chronic kidney disease or polycystic kidney disease (PKD) or undergone dialysis?
(b) Angina or a heart attack or undergone coronary angioplasty (with or without a stent insertion) or coronary artery bypass surgery?
(c) Cerebrovascular accident (stroke)?
☐ No ☐ Yes

8. In the past three (3) years, have you been diagnosed with, hospitalized for, or undergone treatment (including medication) for leukemia or cancer (other than basal cell carcinoma)? ☐ No ☐ Yes

9. Have you ever been diagnosed with diabetes (other than gestational diabetes) **and** had any of the following conditions in the past three (3) years:
(a) Heart attack?
(b) Angina?
(c) Cerebrovascular accident (stroke)?
(d) Peripheral vascular disease?
(e) Gangrene?
(f) Amputation?
(g) Hypoglycemic coma?
☐ No ☐ Yes

10. In the past ten (10) years, have you required the administration of oxygen for a chronic respiratory disorder (other than sleep apnea)? ☐ No ☐ Yes

11. In the past twelve (12) months, have you been:
(a) Hospitalized for any respiratory disorder?
(b) Treated with oral Prednisone or other oral corticosteroid for any respiratory disorder?
☐ No ☐ Yes

12. In the past three (3) years, have you been diagnosed with or hospitalized for:
(a) Hepatitis B or C?
(b) Cirrhosis of the liver?
(c) Chronic pancreatitis?
(d) Two (2) or more episodes of acute pancreatitis?
☐ No ☐ Yes

DECLARATION OF INSURABILITY FOR **GOLDEN PROTECTION (CONTINUED)**

13. In the past two (2) years, have you:
   (a) Used narcotics, barbiturates or steroids (other than prescribed by a physician)?
   (b) Used any unprescribed drugs (other than marijuana products or over the counter medications), including but not limited to cocaine, LSD, amphetamines, hallucinogens?
   (c) Used any prescribed or non-prescribed marijuana products more than 6 times per week?
   (d) Been advised by a health professional to discontinue your consumption of alcohol or drugs, or have you received advice or undergone treatment (including medication) for alcohol or drug abuse?
   (e) Been accused or charged with an alcohol-related or a drug-related driving offence or refused a breathalyzer?
   (f) Been incarcerated, 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?

☐ No ☐ Yes

DECLARATION OF INSURABILITY FOR **SILVER PROTECTION.** ALL 8 QUESTIONS MUST BE ANSWERED "NO".

1. Does your weight exceed the weight corresponding to your height in the following table?
   You must obtain the height and weight information of the applicant for Lia, Height ______ Weight ______

Height		Weight		Height		Weight		Height		Weight	
Ft/in	cm	lb	kg	Ft/in	cm	lb	kg	Ft/in	cm	lb	kg
4' 10"	147	236	107	5' 6"	168	303	137	6' 2"	188	379	172
4' 11"	150	244	110	5' 7"	170	312	142	6' 3"	191	389	176
5' 0"	152	252	114	5' 8"	173	321	146	6' 4"	193	399	181
5' 1"	155	260	118	5' 9"	175	330	150	6' 5"	196	409	186
5' 2"	157	268	122	5' 10"	178	339	154	6' 6"	198	419	190
5' 3"	160	276	125	5' 11"	180	349	158	6' 7"	201	429	195
5' 4"	163	285	129	6' 0"	183	359	163	6' 8"	203	439	199
5' 5"	165	294	133	6' 1"	185	369	167	6' 9"	206	449	204

☐ No ☐ Yes

2. Are you currently:
   (a) Admitted to a hospital?
   (b) Residing or are you on a waiting list to reside in a long-term care facility, nursing home, skilled nursing facility or any other facility requiring care of a skilled staff?

☐ No ☐ Yes

3. Are you aware of any signs, symptoms, or any abnormal diagnostic test for which:
   (a) You have not yet consulted a physician?
   (b) You are currently being investigated?
   (c) You have a pending consultation with a medical specialist? (Medical specialist does not include a general practitioner and pending consultation does not include a routine follow-up.)
   (d) You have consulted with medical specialist without having received a diagnosis?
   (e) You are currently awaiting for a surgery (other than day surgery/outpatient surgery)?

☐ No ☐ Yes

4. Have you ever:
   (a) Been diagnosed with, hospitalized for, or undergone treatment (including medication) for cystic fibrosis, HIV, AIDS, or AIDS-related complex?
   (b) Been diagnosed with or undergone treatment (including medication) for muscular dystrophy, Huntington's disease, amyotrophic lateral sclerosis (Lou Gehrig's disease), Alzheimer's disease, or dementia?
   (c) Been advised by a physician that you have a terminal illness for which you are currently receiving Palliative or Hospice care or have discussed this type of care with a health professional?

☐ No ☐ Yes

5. In the past five (5) years, have you:
   (a) Received a bone marrow transplant or an organ transplant (other than a corneal transplant) or were you advised that one was required?
   (b) Been diagnosed with or hospitalized for congestive heart failure or cardiomyopathy?

☐ No ☐ Yes

6. In the past two (2) years, have you been diagnosed with or hospitalized for:
   (a) Chronic kidney disease or polycystic kidney disease (PKD) or undergone dialysis?
   (b) Angina or a heart attack or undergone coronary angioplasty (with or without a stent insertion) or coronary artery bypass surgery?
   (c) Cerebrovascular accident (stroke)?

☐ No ☐ Yes

7. In the past two (2) years, have you been diagnosed with, hospitalized for, or undergone treatment (including medication) for leukemia or cancer (other than basal cell carcinoma)?

☐ No ☐ Yes

8. In the past twelve (12) months, have you been advised by a health professional to discontinue your consumption of alcohol or drugs, or have you received advice or undergone treatment (including medication) for alcohol or drug abuse?

☐ No ☐ Yes

NO DECLARATION OF INSURABILITY FOR **BRONZE PROTECTION**. THIS IS A GUARANTEED ISSUE PRODUCT. PLEASE ENSURE THAT ALL INFORMATION IS FILLED OUT AND THAT THE PRODUCT GUIDELINES ARE FOLLOWED.

8 PRODUCT SELECTION

WHOLE LIFE

Product Name	Coverage Status	Issue Ages	Minimum	Maximum	Sum Insured*	Payment Option
Platinum Protection Whole Life	Immediate	18-70	$10,000	$500,000	$	☐ Life Pay ☐ 20-Pay
		71-80	$10,000	$125,000	$	☐ Life Pay ☐ 20-Pay
		81-85	$10,000	$125,000	$	☐ Life Pay
Golden Protection Elite Whole Life	Immediate	18-70	$10,000	$150,000	$	☐ Life Pay ☐ 20-Pay
		71-80	$5,000	$50,000	$	☐ Life Pay ☐ 20-Pay
		81-85	$5,000	$25,000	$	☐ Life Pay
Golden Protection	Immediate	40-70	$5,000	$100,000	$	☐ Life Pay ☐ 20-Pay
		71-80	$2,500	$50,000	$	☐ Life Pay ☐ 20-Pay
		81-85	$2,500	$25,000	$	☐ Life Pay
Silver Protection	Deferred	40-70	$5,000	$50,000	$	☐ Life Pay ☐ 20-Pay
		71-80	$2,500	$25,000	$	☐ Life Pay ☐ 20-Pay
		81-85	$2,500	$25,000	$	☐ Life Pay
Bronze Protection	Deferred	18-70	$5,000	$50,000	$	☐ Life Pay
		71-80	$2,500	$25,000	$	☐ Life Pay

TERM

Product Name	Coverage Status	Issue Ages	Minimum	Maximum	Sum Insured*	Payment Option
Platinum Protection Term	Immediate	18-70	$50,000 (ages 18 to 44) $25,000 (ages 45 to 70)	$500,000	$	☐ T10 ☐ T20
Golden Protection Elite Term	Immediate	18-70	$50,000 (ages 18 to 44) $25,000 (ages 45 to 70)	$150,000	$	☐ T10 ☐ T20

ADDITIONAL BENEFIT RIDERS

Product Name	FRAC (max. age of proposed insured is 69)	AD** (max. age of proposed insured is 55)	CIB (max. age of proposed insured is 60)
Platinum Protection Whole Life	☐ 1 unit ☐ 2 units	☐ $____________	☐ $10,000 ☐ $20,000
Golden Protection Elite Whole Life	☐ 1 unit ☐ 2 units	☐ $____________	☐ $10,000 ☐ $20,000
Golden Protection	☐ 1 unit ☐ 2 units	N/A	N/A
Silver Protection	☐ 1 unit ☐ 2 units	N/A	N/A
Bronze Protection	N/A	N/A	N/A

**Must not exceed the maximum combined amounts for a Simplified Issue policy in force with Assumption Life.*
***AD rider amount cannot be greater than the initial sum insured.*

9 PREMIUM AND METHOD OF PAYMENT

Method of payment (Indicate the total premium for the contract according to the method of premium payment)*:

☐ **Monthly (PAD) $**__________ (See "Section 10") ☐ **Annual $**__________ ☐ **Semi-annual $**____________ ☐ **Quarterly $**__________

(a) Amount paid with application $ ______________

(b) Payer: ☐ Proposed Insured ☐ Owner (as specified in Section 2) ☐ Other (Complete below)

Name ___________________________________ Address ____

**Insurance premiums may be subject to Provincial Sales Tax (PST)*

10 PREAUTHORIZED DEBIT (PAD) AGREEMENT (ONLY IF PAD WAS CHOSEN)

Banking Information

If the banking information was not provided in the application, please attach a blank cheque marked void.

Complete only if a "VOID" sample cheque is not available, if the cheque is not preprinted or if this is a savings account.

Name of Financial Institution ______________________________________ Address ____

Branch Number ____________________ Bank Number ___________________ Account Number ________________________________

Type of Service: ☐ Personal - If debit is from a personal account ☐ Business - If debit is from a corporate account

Withdrawal Arrangements This preauthorized debit agreement is considered a variable one.

- I authorize Assumption Life to begin deductions, at any time, as per my instructions for regular recurring payments for the **amount indicated in the application**.
- If a preauthorized debit is returned due to **insufficient funds (NSF) in the account**, Assumption Life will withdraw the related $25 fee from the same account, without notice.
- I agree to the debiting of my account on the ______ (1st to 28th day of the month) or the next business day (subject to change).*

** The first withdrawal from your account will be made the first business day following the date of policy issue, taking into account your financial institution's processing time. The next withdrawal date will be consistent with your PAD agreement. Please note that this could result in two premium withdrawals in the same month.*

- I accept that my bank account be debited for the first PAD as of the date of signing of the application, if all preconditions for the conditional temporary agreement are met. Check the box if you refuse. ☐

Waivers I waive the right to receive 10 days' notice of an increase or decrease in the amount of automatic withdrawal or a change in the date of the withdrawal.*
Cancellation You may cancel this preauthorized debit agreement at any time, subject to providing Assumption Life with 10 days' written notice. Contact your financial institution about your rights regarding cancellation. (A sample cancellation form is available at www.cdnpay.ca.)

Method of Payment Any cancellation of this preauthorized debit agreement will not affect the agreement between you and Assumption Life whatsoever, so long as payment is provided by an alternate method.

Recourse & Reimbursement You have certain recourse rights if any debit does not comply with this agreement. For example, you have the right to receive reimbursement for any debit that is not authorized or is not consistent with this PAD Agreement. To obtain more information on your recourse rights, contact your financial institution or visit www.cdnpay.ca.

Exclusive rights All amounts transferred from the preauthorized bank account for the premium payment are for the exclusive benefit of the Owner of the insurance policy.

**Assumption Life will not increase your preauthorized debit or change your debit date after your insurance contract becomes effective without notifying you.*

11 SPECIAL INSTRUCTIONS

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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/advisor) – Please print ____

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Individual Insurance • Group Insurance • Investments and Retirement

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Assumption Mutual Life Insurance Company, doing business under the name Assumption Life