Assumption Life

Give this copy to Proposed Insureds and to Owners

NOTICE

RECORDS AND PERSONAL INFORMATION

In order to protect the confidentiality of your personal information, Assumption Life is responsible for ensuring that a file is established and retained according to the applicable rules, in the offices of Assumption Life or third parties acting on our behalf, in Canada or elsewhere, in which the information pertaining to your application for insurance, as well as the information pertaining to any insurance claim, will be placed. This personal information may be medical in nature or related to your lifestyle (driving record, pursuit of a hazardous sport, criminal record, etc.). When reviewing your insurance application or assessing a claim, we, our service providers or our reinsurers may consult any insurance file that we hold or that is held by other insurers or reinsurers with respect to any other insurance application or statement you may have made in the past.

For underwriting purposes or in the event of a claim, we could retain the services of an investigator in order to conduct an investigation in regard to you. This investigation may bear on your reputation, health, finances and lifestyle. In the course of this investigation, family members, friends and neighbors may be questioned about you.

We may also, for medical underwriting purposes, seek the assistance of a physician or a paramedical organization or a clinic in order to have you undergo a medical examination, X-rays, an electrocardiogram or to collect a blood, urine or saliva sample. The analysis will be used to determine the existence of various abnormalities such as diabetes, hepatic disorders, kidney or liver disorders, bone disease, immune disorder, infections caused by the AIDS virus, and the presence of medication, drugs, nicotine or their metabolites and to determine cholesterol and blood lipid levels.

In the event of a claim, we may require a copy of your medical records. We may also require, in the event of a death claim, a copy of the police investigation report, coroner's report, or any other report that provides relevant information explaining the circumstances of your death.

When reviewing your insurance application or for underwriting purposes, your personal and medical information may be disclosed to your insurance agent if this information is necessary for the performance of the agent's duties. Only those employees or agents (including any reinsurer, health care professional or service provider) who need the personal information for the performance of their duties will have access to your file. If necessary, your personal information, including your medical information, may also be shared with your beneficiaries or personal representative in relation to a claim for a death benefit.

Your personal information may be securely used, stored or accessed in other countries and may be subject to the laws of those countries. We may have to disclose your personal information in response to a request from government authorities or a court order in these countries.

Assumption Life shall not communicate your personal information to a third party without your consent unless required to do so by law or ordered to do so by a court.

You are entitled to consult any personal information held in your file and, if applicable, to have it corrected by submitting a written request to the following address: ASSUMPTION LIFE, c/o Underwriting Department, P.O. Box 160, Moncton NB E1C 8L1. Telephone: 506-853-6040 or 1-800-455-7337 / Fax: 855-230-2500.

NOTICE FROM MIB, LLC (MIB)

Information regarding your insurability will be treated as confidential. Assumption Life or its reinsurers may, however, make a brief report thereon to MIB, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or accident and sickness insurance coverage, or a claim for benefits is submitted to such company, MIB, upon request, will supply such company with the information in its files. As a U.S.-based company, MIB is bound by, and such personal information may be disclosed in accordance with, applicable U.S. laws.

Upon receipt of a request from you, MIB will arrange disclosure to you of any information it may have in your file. Please contact MIB at 866-692-6901. If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedure set forth in the U.S. federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734. To learn more about MIB, visit www.mib.com.

Assumption Life, or its reinsurer(s), may also release any information in its file to other insurance companies to whom you may apply for life or accident and sickness insurance, or to whom a claim for benefits may have been submitted.

Assumption Mutual Life Insurance Company, doing business under the name Assumption Life
770 Main Street, P.O. Box 160 Moncton NB E1C 8L1 Tel. 506-853-6040 / 1-800-455-7337 Fax 855-230-2500

Declaration of Insurability

For Platinum Protection Whole Life and Platinum Protection Term

Assumption Life

Policy/Contrat No. ____________________

Name of Insured ______________________________ **Name of Owner (s)** ______________________________

Application for ☐ reinstatement ☐ delivery ☐ change from ____________________ to ____________________
☐ change from **smoker** to **non-smoker** ☐ other change ______________________________

- **Do not submit this form if you have answered "yes" to any of the questions 2 through 20.**

		Yes	No
1.	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?	☐	☐
2.	Does your weight exceed the weight corresponding to your height in the following table?	☐	☐

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

		Yes	No
3.	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)?	☐	☐
4.	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?	☐	☐
5.	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)?	☐	☐
6.	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?	☐	☐
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?	☐	☐
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)?	☐	☐
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)?	☐	☐

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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?	☐	☐
11.	In the **past ten (10) years**, have you required the administration of oxygen for a chronic respiratory disorder (other than sleep apnea)?	☐	☐
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?	☐	☐
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?	☐	☐
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)?	☐	☐
15.	Is your driver's license currently suspended or revoked as a result of any driving infractions?	☐	☐
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?	☐	☐
17.	In the **past three (3) months**, have you required a new medication for high blood pressures or an increase in the dosage of any medication for high blood pressure?	☐	☐
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?	☐	☐
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?	☐	☐
20.	**For insured age 50 or under**, 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?	☐	☐

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AUTHORIZATION FOR REINSTATEMENT, DELIVERY AND CHANGE

I request that Assumption Life reinstate and/or make the above change(s) to this contract. It is agreed that all information given in connection with this declaration of insurability is material to the consideration for acceptance by Assumption Life. It is also agreed that the reinstatement and change(s) requested in this declaration will take effect from the date of approval by Assumption Life provided overdue and/or required premiums and other indebtedness have been paid and the proof of health is found satisfactory to Assumption Life.

I understand that the reinstatement of the policy and of any riders will also result in the reinstatement of the two-year limitation period during which Assumption Life may void the contract if the Insured commits suicide or makes a false statement. If, within two years from the date of approval of reinstatement, the Insured commits suicide or if any statement in this declaration of insurability is false or if there is failure to disclose all facts material to the insurance, the reinstatement of the policy or rider shall be void, and any changes may be cancelled by Assumption Life.

I authorize any physician, health care professional, hospital, clinic or other medical or paramedical establishment, as well as any insurance company, MIB, LLC (MIB), a credit agency, and any other organization, institution or person that holds records or information pertaining to me or my health status to exchange such records or information with Assumption Life or its reinsurers for claims adjudication purposes.

I authorize Assumption Life to retain the services of an investigator in order to conduct an investigation on me in the event of a claim. I understand that this investigation may bear on my reputation, health, finances and lifestyle.

In the event of a claim, I authorize any coroner, police force and any other agency that holds information regarding my death to communicate such information to Assumption Life and its reinsurers.

I acknowledge receipt of Assumption Life's **Notice for records and personal information** and from **MIB, LLC** and agree with all its terms and conditions.

I authorize Assumption Life, or its reinsurers, to make a brief report on my personal health information to MIB.

This authorization remains valid after my death.

I acknowledge that a reproduction of this authorization shall be as valid as the original.

Signed at ____, this____________day of ________________________________ 20 ______________

Insured's signature ____

Owner's signature*____ Title ______________________

(if other than Insured)

Agent's signature ____

Agent's code__________

Owner's signature*____ Title ______________________

* If the Owner is a Body Corporate (corporation, association, etc.), the signature of the authorized individuals and their title are required.

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