DATA COLLECTION FORM FOR **SIMPLIFIED ISSUE PRODUCTS**

Assumption Life

6666-00A-JUN24

ERASE

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

**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.

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						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 SELECTION

WHOLE LIFE

Product Name	Coverage Status	Issue Ages	Minimum	Maximum	Sum Insured**	Payment Option
Platinum Protection Whole Life *Declaration of insurability starts on page 5*	Immediate	18-50	$10,000	$750,000	$	☐ Life Pay ☐ 20-Pay
		51-75	$10,000	$500,000	$	☐ Life Pay ☐ 20-Pay
		76-80	$10,000	$250,000	$	☐ Life Pay ☐ 20-Pay
		81-85	$10,000	$250,000	$	☐ Life Pay
Golden Protection Whole Life *Declaration of insurability starts on page 7*	Immediate	18-75	$5,000	$250,000	$	☐ Life Pay ☐ 20-Pay
		76-80	$5,000	$100,000	$	☐ Life Pay ☐ 20-Pay
		81-85	$5,000	$100,000	$	☐ Life Pay
Silver Protection *Declaration of insurability starts on page 9*	Graded Deferred*	18-75	$5,000	$50,000	$	☐ Life Pay ☐ 20-Pay
		76-80	$5,000	$25,000	$	☐ Life Pay ☐ 20-Pay
		81-85	$5,000	$25,000	$	☐ Life Pay
Bronze Protection *This is a guaranteed issue product. No declaration of insurability is required for Bronze Protection.*	Deferred	18-75	$5,000	$50,000	$	☐ Life Pay
		76-80	$5,000	$25,000	$	☐ Life Pay

TERM

Product Name	Coverage Status	Issue Ages	Minimum	Maximum	Sum Insured**	Payment Option
Platinum Protection Term *Declaration of insurability starts on page 5*	Immediate	18-44	$50,000	$750,000	$	☐ Term 10 ☐ Term 20
		45-50	$25,000	$750,000	$	☐ Term 10 ☐ Term 20
		51-70	$25,000	$500,000	$	☐ Term 10 ☐ Term 20
		71-75	$25,000	$500,000	$	☐ Term 10
Golden Protection Term *Declaration of insurability starts on page 7*	Immediate	18-44	$50,000	$250,000	$	☐ Term 20
		45-70	$25,000	$250,000	$	☐ Term 20

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
Platinum Protection Term	☐ 1 unit ☐ 2 units	☐ $_____	☐ $10,000 ☐ $20,000
Golden Protection Whole Life	☐ 1 unit ☐ 2 units	N/A	N/A
Golden Protection Term	☐ 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

**Graded deferred death benefit is equal to: Premiums paid with interest at 3% per annum if the insured's death is non-accidental and occurs before the 1st policy or rider anniversary. 50% of the sum insured if the insured's death is non-accidental and occurs between the 1st and before the 2nd policy or rider anniversary. 100% of the sum insured if the insured's death is non-accidental and occurs on or after the 2nd policy or rider anniversary.*

***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.*

Platinum Protection Declaration of Insurability

If you answered "NO" to all 19 questions listed below, you qualify for Platinum Protection.

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. 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. In the past 12 months, has your weight decreased by more than 9.08 kg (20 lbs) other than due to pregnancy, a bariatric surgery, intentional dieting, or exercise?

☐ No ☐ Yes

4. In the past 6 months, have you undergone a bariatric surgery?

☐ No ☐ Yes

5. Are you aware of any signs, symptoms, or abnormal medical tests for which:
(You don't need to tell us about common cold or flu symptoms, routine follow-up where there are no new symptoms, or routine prenatal visit.)
   a) You have not yet consulted a physician, or you have consulted a physician without having received a diagnosis?
   b) You are currently being investigated?
   c) You have a pending consultation with a medical specialist? (A pending consultation does not include a routine follow-up, and a medical specialist does not include a general practitioner.)
   d) You have consulted a medical specialist without having received a diagnosis?
   e) You are currently waiting for a surgery (other than a surgery that does not require an overnight hospital stay such as a day surgery/ outpatient surgery)?

☐ No ☐ Yes

6. Have you ever:
   a) 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?
   b) Had a pacemaker or implantable cardio-defibrillator (ICD) inserted?

☐ No ☐ Yes

7. Have you ever been diagnosed with:

Immune System
a) AIDS (acquired immune deficiency syndrome) or tested positive for HIV (the virus that causes AIDS)?

Nervous System
b) Huntington's disease, amyotrophic lateral sclerosis (Lou Gehrig's disease), Alzheimer's disease, or dementia?

Cardiovascular System
c) Congestive heart failure?

Gastro-Intestinal System
d) Cirrhosis of the liver, chronic pancreatitis, or two or more episodes of acute pancreatitis?

Respiratory System
e) Cystic fibrosis?

Musculoskeletal System
f) Muscular dystrophy?

☐ No ☐ Yes

8. Have you ever been diagnosed with diabetes (other than gestational diabetes) and ever had any of the following conditions: heart attack (myocardial infarction), angina, cerebrovascular accident (stroke), peripheral vascular/artery disease, gangrene, amputation related to complications of your diabetes (such as poor circulation or infection), hypoglycemic coma, neuropathy, or nephropathy?

☐ No ☐ Yes

9. In the past 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, hospitalized for, or received treatment (including treatment with any prescribed medication) for cardiomyopathy or hepatitis B or C?
   c) Required the administration of oxygen for a chronic respiratory disorder (other than sleep apnea)?

☐ No ☐ Yes

Platinum Protection Declaration of Insurability (Continued)

10. In the past 5 years, have you been diagnosed with or hospitalized for: **Nervous System and Mental Health** a) Convulsions, epilepsy, paralysis, multiple sclerosis, or bipolar disorder? **Cardiovascular System** b) Angina or a heart attack (myocardial infarction) or undergone coronary angioplasty (with or without a stent insertion) or coronary artery bypass surgery? c) Cerebrovascular accident (stroke) or transient ischemic attack (TIA or mini-stroke)? d) Heart murmur or arrhythmia (irregular heartbeat such as atrial fibrillation/flutter, tachycardia, bradycardia, supraventricular tachycardia, ventricular fibrillation or ectopic beats)? **Gastro-Intestinal System** e) Crohn's disease or ulcerative colitis? **Musculoskeletal System** f) Rheumatoid arthritis? **Genitourinary System** g) Chronic kidney disease or polycystic kidney disease (PKD) or undergone dialysis?	☐ No ☐ Yes
11. In the past 5 years, have you been diagnosed with, hospitalized for, or received treatment (including treatment with any prescribed medication) for any of the following conditions: **Immune System** a) Scleroderma, morphea, crest syndrome, or Systemic Lupus Erythematosus (SLE)? **Nervous System and Mental Health** b) Parkinson's disease, schizophrenia, schizoaffective disorder, or psychosis? **Cancer** c) Leukemia, cancer, lymphoma, or melanoma? You don't need to tell us about basal cell carcinoma. d) Spinal cord or brain tumor?	☐ No ☐ Yes
12. In the past 2 years, were you prescribed a new medication, received an increase in the dosage in your medication or discontinued a medication for arrhythmia (irregular heartbeat), rheumatoid arthritis, Crohn's disease, ulcerative colitis, epilepsy, multiple sclerosis, or bipolar disorder?	☐ No ☐ Yes
13. In the past 2 years, have you been hospitalized for chronic obstructive pulmonary disease (COPD) or emphysema?	☐ No ☐ Yes
14. In the past 12 months, have you been prescribed oral Prednisone or other oral corticosteroid for any respiratory disorder (such as asthma, pneumonia, tuberculosis, acute and chronic bronchitis, chronic obstructive pulmonary disease (COPD), emphysema, bronchiectasis, occupational respiratory disorder, pulmonary embolism, pulmonary sarcoidosis)? Oral Prednisone or other oral corticosteroid does not include inhalers that may contain Prednisone or another corticosteroid.	☐ No ☐ Yes
Question for insured age 50 or under ONLY 15. Do you have a biological family member (father, mother, brother, sister), who was diagnosed with Huntington's disease or polycystic kidney disease (PKD), and for which you have not been investigated for these diseases?	☐ No ☐ Yes
16. In the past 3 years, have you: a) Used cannabis (such as marijuana or hashish) more than 10 times per week? b) Used any other drugs or prescription medications that weren't prescribed to you such as cocaine, LSD, amphetamines, hallucinogens, narcotics, barbiturates, or anabolic steroids? You don't need to tell us about over the counter medications. c) Been advised by a health professional to discontinue or reduce your consumption of alcohol or drugs, or have you received advice or treatment (including treatment with any prescribed medication) for alcohol or drug abuse? d) Been incarcerated, on house arrest, on probation, or convicted of a crime or are you currently accused of a crime for which a verdict has not yet been rendered? e) Been accused or charged with an alcohol or drug-related driving offence or refused a breathalyzer?	☐ No ☐ Yes
17. Is your driver's license currently suspended or revoked as a result of any driving infractions?	☐ No ☐ Yes
18. In the next 12 months, do you expect or plan to engage in any hazardous sports or activities, or aerial flights other than as a fare paying passenger, commercial pilot, or crew member of a commercial flight?	☐ No ☐ Yes
19. In the next 12 months, do you expect or plan to travel outside North America, the Caribbean (excluding Haiti), or Western Europe for more than 12 consecutive weeks?	☐ No ☐ Yes

Golden Protection Declaration of Insurability

If you answered "NO" to all 13 questions listed below, you qualify for Golden Protection.

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. 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. In the past 12 months, has your weight decreased by more than 9.08 kg (20 lbs) other than due to pregnancy, a bariatric surgery, intentional dieting, or exercise?

☐ No ☐ Yes

4. In the past 6 months, have you undergone a bariatric surgery?

☐ No ☐ Yes

5. Are you aware of any signs, symptoms, or abnormal medical tests for which:
   (You don't need to tell us about common cold or flu symptoms, routine follow-up where there are no new symptoms, or routine prenatal visit.)
   a) You have not yet consulted a physician, or you have consulted a physician without having received a diagnosis?
   b) You are currently being investigated?
   c) You have a pending consultation with a medical specialist? (A pending consultation does not include a routine follow-up, and a medical specialist does not include a general practitioner.)
   d) You have consulted a medical specialist without having received a diagnosis?
   e) You are currently waiting for a surgery (other than a surgery that does not require an overnight hospital stay such as a day surgery/ outpatient surgery)?

☐ No ☐ Yes

6. Have you ever 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

7. Have you ever been diagnosed with:
   Immune System
   a) AIDS (acquired immune deficiency syndrome) or tested positive for HIV (the virus that causes AIDS)?
   Nervous System
   b) Huntington's disease, amyotrophic lateral sclerosis (Lou Gehrig's disease), Alzheimer's disease, or dementia?
   Cardiovascular System
   c) Congestive heart failure?
   Gastro-Intestinal System
   d) Cirrhosis of the liver, chronic pancreatitis, or two or more episodes of acute pancreatitis?
   Respiratory System
   e) Cystic fibrosis?
   Musculoskeletal System
   f) Muscular dystrophy?

☐ No ☐ Yes

8. Have you ever been diagnosed with diabetes (other than gestational diabetes) and had any of the following conditions in the past 3 years: heart attack, angina, cerebrovascular accident (stroke), peripheral vascular/artery disease, gangrene, amputation related to complications of your diabetes (such as poor circulation or infection), hypoglycemic coma, neuropathy, or nephropathy?

☐ No ☐ Yes

9. In the past 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, hospitalized for, or received treatment (including treatment with any prescribed medication) for cardiomyopathy or hepatitis B or C?
   c) Required the administration of oxygen for a chronic respiratory disorder (other than sleep apnea)?

☐ No ☐ Yes

10. In the past 3 years, have you been diagnosed with or hospitalized for:
    Cardiovascular System
    a) Angina or a heart attack (myocardial infarction) or undergone coronary angioplasty (with or without a stent insertion) or coronary artery bypass surgery?
    b) Cerebrovascular accident (stroke)?
    Genitourinary System
    c) Chronic kidney disease or polycystic kidney disease (PKD) or undergone dialysis?

☐ No ☐ Yes

Golden Protection Declaration of Insurability (Continued)

11. In the past 3 years, have you been diagnosed with, hospitalized for, or received treatment (including treatment with any prescribed medication) for leukemia, cancer, lymphoma, or melanoma? You don't need to tell us about basal cell carcinoma.	☐ No ☐ Yes
12. In the past 12 months, have you been: a) Hospitalized for chronic obstructive pulmonary disease (COPD) or emphysema? b) Prescribed oral Prednisone or other oral corticosteroid for any respiratory disorder (such as asthma, pneumonia, tuberculosis, acute and chronic bronchitis, chronic obstructive pulmonary disease (COPD), emphysema, bronchiectasis, occupational respiratory disorder, pulmonary embolism, pulmonary sarcoidosis)? Oral Prednisone or other oral corticosteroid does not include inhalers that may contain Prednisone or another corticosteroid.	☐ No ☐ Yes
13. In the past 2 years, have you: a) Used cannabis (such as marijuana or hashish) more than 10 times per week? b) Used any other drugs or prescription medications that weren't prescribed to you such as cocaine, LSD, amphetamines, hallucinogens, narcotics, barbiturates, or anabolic steroids? You don't need to tell us about over the counter medications. c) Been advised by a health professional to discontinue or reduce your consumption of alcohol or drugs, or have you received advice or treatment (including treatment with any prescribed medication) for alcohol or drug abuse? d) Been incarcerated, on house arrest, on probation, or convicted of a crime or are you currently accused of a crime for which a verdict has not yet been rendered? e) Been accused or charged with an alcohol or drug-related driving offence or refused a breathalyzer?	☐ No ☐ Yes

Silver Protection Declaration of Insurability

If you answered "NO" to all 9 questions listed below, you qualify for Silver Protection.

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 abnormal medical tests for which:
   (You don't need to tell us about common cold or flu symptoms, routine follow-up where there are no new symptoms, or routine prenatal visit.)
   a) You have not yet consulted a physician, or you have consulted a physician without having received a diagnosis?
   b) You are currently being investigated?
   c) You have a pending consultation with a medical specialist? (A pending consultation does not include a routine follow-up, and a medical specialist does not include a general practitioner.)
   d) You have consulted a medical specialist without having received a diagnosis?
   e) You are currently waiting for a surgery (other than a surgery that does not require an overnight hospital stay such as a day surgery/ outpatient surgery)?

☐ No ☐ Yes

4. Have you ever 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. Have you ever been diagnosed with:
   Immune System
   a) AIDS (acquired immune deficiency syndrome) or tested positive for HIV (the virus that causes AIDS)?
   Nervous System
   b) Huntington's disease, amyotrophic lateral sclerosis (Lou Gehrig's disease), Alzheimer's disease, or dementia?
   Cardiovascular System
   c) Congestive heart failure?
   Respiratory System
   d) Cystic fibrosis?
   Musculoskeletal System
   e) Muscular dystrophy?

☐ No ☐ Yes

6. In the past 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 cardiomyopathy?

☐ No ☐ Yes

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

☐ No ☐ Yes

8. In the past 2 years, have you been diagnosed with, hospitalized for, or received treatment (including treatment with any prescribed medication) for leukemia, cancer, lymphoma, or melanoma? You don't need to tell us about basal cell carcinoma.

☐ No ☐ Yes

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

☐ No ☐ Yes

No declaration of insurability is required 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 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)*

9 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.*

10 SPECIAL INSTRUCTIONS

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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