FlexOptions

# Data Collection Form – Complete this form for *each* insured

**This is not an application. Do not submit.**

**The information in this document is only valid once uploaded into Assumption Life's electronic sales platform, Lia**

**Policy option:** ☐ Individual ☐ Joint first-to-die

This form is for: ☐ Proposed Insured 1 ☐ Proposed Insured 2 *(Joint-first-to-die)*

☐ Proposed Insured #___ (WP on Owner ☞complete sections A, G, H, I) ☐ Proposed Insured #___ (WP on Payer ☞complete sections A, G, H, I)

## A. PROPOSED INSURED INFORMATION

| | |
|---|---|
| First Name | Address |
| Last Name | City |
| Previous Last Name | Province |
| Occupation | Postal Code |
| Name of Employer | Home Tel._ _ _ - _ _ _ - _ _ _ _ Work Tel._ _ _ - _ _ _ - _ _ _ _ |
| Annual (Employment) Income | E-mail |
| Province of Birth | Date of Birth _ _ / _ _ _ / _ _ _ _ (DD MMM YYYY) (Example: 01/JAN/2014) |
| Country of Birth | Sex ☐ M ☐ F |
| Present residency status in Canada:<br>☐ Canadian citizen<br>☐ Permanent resident (landed immigrant)<br>☐ Other (specify) _____<br>If other, indicate date of status _ _ / _ _ _ / _ _ _ _ (DD MMM YYYY) | *In the past twelve (12) months, have you used any substance or product containing tobacco, nicotine, or marijuana mixed with nicotine, or used e-cigarettes?*<br>Smoker: ☐ No ☐ Yes |

## B. INSURANCE REQUESTED

**FlexOptions** ☐ 15 yrs ☐ 20 yrs ☐ 25 yrs Sum Insured (Min. $50,000. – Max. $4,000,000) $ _____

Additional Benefit Riders: The maximum age for these riders is 55.

☐ DI based on loans (Loan repayment option) $_____ per month *(min. $300, max. $3 000 or at most 1% of the FlexOptions sum insured)*

☐ DI based on employment income (Income replacement option) $_____ per month *(min. $300, max. $3 000 or at most 1% of the FlexOptions sum insured or 75% of the annual employment income divided by 12)*

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

☐ Waiver of premium upon disability (WP)*

** If WP is for owner or payer, please use a separate form, complete only sections A, G, H, I and check only the WP under section " Insurance Requested".*

☐ 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) _____

2) _____

3) _____

4) _____

5) _____

## C. PAYMENT METHOD *(Complete only on data collection form for **Proposed Insured 1**)*

☐ Annual ☐ Monthly (PAD)

☐ Semi- Annual

☐ Quarterly

Regular preauthorized debit (PAD) withdrawal day:

☐ Coïncides with day of application approval by Assumption Life

☐ On the_____ (1st to 28th) day of the month



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## D. REPLACEMENT

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

* If Yes, please ensure that you satisfy the Proposed Insured's province's disclosure requirements pertaining to the replacement of a life insurance policy. Moreover, if the original policy being replaced is with Assumption Life, a written notice or a ''policy service request'' signed by the owner of the original policy must be sent to Assumption Life in order to terminate the existing policy.

## E. 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):

_____

## F. BENEFICIARY UPON DEATH OF THE PROPOSED INSURED *(Complete only on data collection form for **Proposed Insured 1 and 2**)*

| | First Name and Last Name | Age | % | Beneficiary type ** | Relationship with Proposed Insured (In Québec, relationship with the owner) |
|---|---|---|---|---|---|
| Primary | _____ | ____ | ____ | ☐ Irrevocable ☐ Revocable | _____ |
| | _____ | ____ | ____ | ☐ Irrevocable ☐ Revocable | _____ |
| | If a % is indicated the total must equal 100 %. | | | | |
| Substitute | _____ | ____ | ____ | | _____ |
| *(Replace the primary beneficiary if he/she die before the proposed insured )* | _____ | ____ | ____ | | _____ |
| | If a % is indicated the total must equal 100 %. | | | | |
| Contingent | _____ | ____ | ____ | ☐ Irrevocable ☐ revocable | _____ |
| *(Upon death of all primary and substitute beneficiaries)* | _____ | ____ | ____ | ☐ Irrevocable ☐ Revocable | _____ |
| | If a % is indicated the total must equal 100%. | | | | |

Assign a Trustee (optional) — Relationship to Beneficiary

_____ _____

_____ _____

* In Quebec, the designation by the owner of a married or civil union spouse as beneficiary is irrevocable, unless otherwise stipulated. All other beneficiary designations are revocable. The designation of an irrevocable beneficiary limits your rights under the contract and his/her consent will be required for all future transactions including withdrawals and changes of beneficiary.

## G. OWNER/PAYER INFORMATION *(Complete only on data collection form for Proposed Insured 1)*

| | | | | | |
|---|---|---|---|---|---|
| Owner: | ☐ Proposed Insured 1 | ☐ Proposed Insured 2 | ☐ Other or Body Corporate (complete below) | | |
| Co-owner: | ☐ Proposed Insured 1 | ☐ Proposed Insured 2 | ☐ Other (complete below) | | |
| Payer: | ☐ Proposed Insured 1 | ☐ Proposed Insured 2 | ☐ Owner | ☐ Co-owner | ☐ Other (complete below) |

**Banking Information** ***(If possible, please include a personal cheque marked "VOID")***

Bank Name

Bank Number — Branch Number — ☐ Savings ☐ Chequing

Account Number

***Complete if owner is a Body Corporate*** *(corporation, partnership, etc.)*

Name of Body Corporate

Registration Number — Names of Directors

Address

City

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

Postal Code — Name — Title

Telephone — Name — Title



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***Complete if owner is Other***

| | |
|---|---|
| Check below if applicable and complete only first name and last name. | Address |
| ☐ See data form for WP on Owner named afterward. | City |
| First Name | Province |
| Last Name | Postal Code |
| Date of Birth _ _/_ _ _/_ _ _ _ | Home Telephone |
| DD MMM YYYY (Example 01/JAN/2014) | Work Telephone |
| Copy address : Proposed Insured ☐ 1 ☐ 2 | E-mail |
| | Relationship with Proposed Insured |

***Complete if co-owner or payer is Other***

| | |
|---|---|
| Check below if applicable and complete only first name and last name. | Address |
| ☐ See data form for WP on Payer named afterward. | City |
| First Name | Province |
| Last Name | Postal Code |
| Date of Birth * _ _/_ _ _/_ _ _ _ | Home Telephone |
| DD MMM YYYY (Example 01/JAN/2014) | Work Telephone |
| Copy address : Proposed Insured ☐ 1 ☐ 2 | E-mail |
| **** These fields do not have to be completed for the payer.*** | Relationship with Proposed Insured * |

## H. DECLARATION OF INSURABILITY

| | | | |
|---|---|---|---|
| **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)? | ☐ No ☐ Yes |
| **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? | ☐ No ☐ Yes |
| | (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? | ☐ No ☐ Yes |
| | (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? | ☐ No ☐ Yes |
| | (d) | Sleep apnea, respiratory or lung disorder, disorder of the stomach, liver, pancreas or intestines, including hepatitis B or C, or chronic diarrhea? | ☐ No ☐ Yes |
| | (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? | ☐ No ☐ Yes |
| | (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)? | ☐ No ☐ Yes |
| | (g) | Diabetes, disorder of the glands (other than controlled hypothyroidism) or lymph nodes, or other unexplained infections? | ☐ No ☐ Yes |
| | (h) | AIDS (acquired immune deficiency syndrome), ARC (AIDS-related complex), AIDS virus antibody, or any other immunological disorder? | ☐ No ☐ Yes |
| **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? | ☐ No ☐ Yes |
| **4.** | | In the past five (5) years, have you been convicted of impaired driving? If YES, complete and attach the Driving Record Questionnaire (4018). | ☐ No ☐ Yes |
| **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). | ☐ No ☐ Yes |
| **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). | ☐ No ☐ Yes |
| **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? | ☐ No ☐ Yes |
| **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). | ☐ No ☐ Yes |



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| | | |
|---|---|---|
| **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). | ☐ No ☐ Yes |
| **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). | ☐ No ☐ Yes |
| **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? | ☐ No ☐ Yes |
| **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? | ☐ No ☐ Yes |
| **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. | ☐ No ☐ Yes |
| **14.** | Does your weight exceed the weight corresponding to your height in the following table? | ☐ 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** | 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? | ☐ No ☐ Yes |

## I. RIDERS - *Questions below must be answered if one of the following additional benefit riders is chosen.*

**Waiver of Premium upon Disability**

The waiver of premium upon disability terminates on the first of the following: on the expiry date of the policy's 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: | ☐ No ☐ Yes |
| (a) | Been absent from work due to injury or illness for more than thirty (30) consecutive days? | ☐ No ☐ Yes |
| (b) | Applied for or received a disability benefit or compensation due to injury, illness or disability? | ☐ No ☐ Yes |
| (c) | Consulted or received any treatment from a physiotherapist, massage therapist, chiropractor or acupuncturist? | ☐ No ☐ Yes |

**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? | ☐ No ☐ Yes |
| | By adding the number of hours worked in the **past three (3) months**, have you been working on average fewer than twenty (20) hours per week? | ☐ No ☐ Yes |
| | 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? | ☐ No ☐ Yes |
| (b) | Applied for or received a disability benefit or compensation due to injury, illness or disability? | ☐ No ☐ Yes |
| (c) | Consulted or received any treatment from a physiotherapist, massage therapist, chiropractor or acupuncturist? | ☐ No ☐ Yes |



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**Loan Information** *(Complete only if **DI based on loans** is chosen)*

- The initial amortization period of the loan must be at least 15 years.
- The remaining loan period must be at least 5 years for the loan to be eligible for income disability.
- The expected start date for a real estate mortgage loan can be deferred up to six months from the application date.
- The personal line of credit must have a minimum credit limit of $20,000.

| Loan Description | Initial amortization period | Deferred Real Estate Mortgage Loan | Financial Institution | Initial loan amount or line of credit limit | Remaining loan period | Loan expiry date |
|---|---|---|---|---|---|---|
| | 15 years or more? | If deferred, check and indicate expected start date of the loan | | Approx. | Yrs Months | or MM YYYY |
| | ☐ Yes ☐ No | ☐ Deferred _____ DD/MMM/YYYY | | | | |
| | ☐ Yes ☐ No | ☐ Deferred _____ DD/MMM/YYYY | | | | |
| | ☐ Yes ☐ No | ☐ Deferred _____ DD/MMM/YYYY | | | | |

## J. FOR ALL "YES" ANSWERS *(for section G and H)*

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

## K. Special Instructions *(Complete only on data collection form for **Proposed Insured 1**)*

☐ Date of issue coincides with the day the application is approved by Assumption Life except if approved on the 29th, 30th or 31st where the date of issue shall be on the 28th day of the month.

☐ Date of issue requested (DD/MMM/YYYY): _____ /_____ /_____ (Example: 01/JAN/2014)

- 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



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## QUESTIONS TO OBTAIN THE CONDITIONAL TEMPORARY INSURANCE AGREEMENT

**ONLY FOR FLEXOPTIONS, FLEXTERM, YOUTH PLUS, 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 |
|---|---|---|---|---|
| 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? | ☐No ☐Yes | ☐No ☐Yes | ☐No ☐Yes |
| CI & Life / Life | (b) Have you ever had an application for life insurance declined, cancelled, modified (with higher premiums or an exclusion) or postponed? | ☐No ☐Yes | ☐No ☐Yes | ☐No ☐Yes |
| 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)? | ☐No ☐Yes | ☐No ☐Yes | ☐No ☐Yes |
| 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)? | ☐No ☐Yes | ☐No ☐Yes | ☐No ☐Yes |
| 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? | ☐No ☐Yes | ☐No ☐Yes | ☐No ☐Yes |
| 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? | ☐No ☐Yes | ☐No ☐Yes | ☐No ☐Yes |

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.



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# Notes



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