FlexTERM

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 # ____ *(FlexTerm rider)*

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

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:

☐ Canadian citizen

☐ Permanent resident (landed immigrant)

☐ Other (specify) _____

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?

Smoker: ☐ No ☐ Yes

B. INSURANCE REQUESTED

FlexTerm ☐ 10 yrs ☐ 15 yrs ☐ 20 yrs ☐ 25yrs ☐ 30 yrs ☐ 35 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 FlexTerm sum insured)*

☐ DI based on employment income (Income replacement option) $_____ per month *(min. $300, max. $3 000 or at most 1% of the FlexTerm 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 death (WPD) *

☐ Waiver of premium upon disability (WP) *

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

☐ FlexTerm ☐ 10 yrs ☐ 15 yrs ☐ 20 yrs ☐ 25 yrs ☐ 30 yrs ☐ 35 yrs ☞ Sum Insured (Min. $50,000. – Max. $4,000,000) $ _____

** If WP is for owner or payer, please use a separate form, complete only sections A, H, I, J and check only the WP and/orWPD 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. FLEX TERM LIFE INSURANCE RIDERS (max 5)

Insured # ___ Name _____
Insured # ___ Name _____
Insured # ___ Name _____
Insured # ___ Name _____
Insured # ___ Name _____

YOUTH PLUS LIFE INSURANCE RIDERS (max 5)

Insured # ___ Name _____
Insured # ___ Name _____
Insured # ___ Name _____
Insured # ___ Name _____
Insured # ___ Name _____

↳ **The Data Collection Form must be completed for the chosen product.**

E. 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.

F. 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): _____

G. 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 Quebec, 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 *(Upon death of all primary and substitute beneficiaries)*

_____	___	___	☐ Irrevocable ☐ Revocable	_____
_____	___	___	☐ 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.

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H. 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

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 *

I. 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

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(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

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

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J. 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 is not renewable and terminates on the first of the following: on the expiry date of the policy's first term; on the rider anniversary nearest to the Insured's 60th birthday. The owner cannot be a Body Corporate (corporation, partnership, etc.).

☐ **I have read the above statement and confirm that the Owner understands the terms and conditions.**

In the **past three (3) years**, have you:

(a)	Been absent from work due to injury or illness for more than thirty (30) consecutive days?	☐ 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

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				

K. FOR ALL "YES" ANSWERS *(for section H and I)*

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

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L. CHILD'S INSURANCE BENEFIT (CIB)

Complete only if checked in the "INSURANCE REQUESTED" section.

List each natural or adopted child of Proposed Insured who is single and dependent upon this person for support:

	First and Last Name	Date of Birth day/month/year	Age	Sex	Height ft/in or m/cm	Weight lb-oz or kg-g
(a)						
(b)						
(c)						
(d)						
(e)						

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

M. FOR ALL "YES" ANSWERS *(for section L)*

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

N. 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
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
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
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
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	(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	(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

CI & Life

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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