Youth Plus

Data Collection - 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 the Assumption Life e-commerce process.

This form is for:

☐ Proposed Insured 1 ☐ Proposed Insured # ____ *(youth Plus Rider)*

☐ Proposed Insured #____ (WP/WPD on Owner ☞complete sections A, I, J) ☐ Proposed Insured #____ (WP/WPD on Payer ☞complete sections A, I, J)

A. PROPOSED INSURED INFORMATION

First Name	Address
Last Name	City
Previous Last Name	Province
Occupation ☐ Preschool ☐ Student ☐ Other: _____	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/2011)
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

Youth Plus - Sum Insured

☐ $35 000	☐ $87 500	☐ $140 000
☐ $52 500	☐ $105 000	☐ $157 500
☐ $70 000	☐ $122 500	☐ $175 000

Additional Benefit Riders:

☐ Accidental Death & Dismemberment (AD&D) *: $_____

☐ Waiver of premium upon death (WPD) on Owner

☐ Waiver of premium upon disability (WP) on Owner

☐ Waiver of premium upon death (WPD) on Payer

☐ Waiver of premium upon disability (WP) on Payer

** AD&D Rider amount cannot be greater than the initial sum insured.*

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

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): _____

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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 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.

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

Complete if owner is Other

Check below if applicable and complete only first name and last name.

☐ See data form for WP on Owner named afterward.

First Name

Last Name

Date of Birth _ _ / _ _ _ / _ _ _ _ (DD MMM YYYY) (Example 01/JAN/2011)

Copy address : Proposed Insured ☐ 1 ☐ 2

Address

City

Province

Postal Code

Home Telephone — Work Telephone

E-mail

Relationship with Proposed Insured

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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/2011)	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 ON PROPOSED INSURED FOR YOUTH PLUS

1.	Has the Proposed Insured been advised to consult a medical specialist or have any analysis or diagnostic tests which have not yet been undertaken or for which results are not yet known? (Medical specialist does not include a general practitioner.)	☐ No ☐ Yes
2.	Was the Proposed Insured born prematurely or with an abnormality or disease?	☐ No ☐ Yes
3.	Has the Proposed Insured been hospitalized or undergone any surgery or waiting to be hospitalized or to undergo surgery?	☐ No ☐ Yes
4.	Is the Proposed Insured currently undergoing treatment, including medication, or under medical observation?	☐ No ☐ Yes
5.	Does the Proposed Insured suffer from any disease, disorder, syndrome or physical or mental condition?	☐ No ☐ Yes
6.	Has the Proposed Insured ever used any drugs (including but not limited to marijuana, cocaine, LSD, amphetamine hallucinogens, or unprescribed narcotics) or has he/she received advice or treatment for alcohol or drug abuse? If YES, comple and attach the appropriate questionnaire: Drug (3887), Alcohol (3876).	☐ No ☐ Yes
7.	Has the Proposed Insured ever engaged in any hazardous sports or activities or intend to engage in such sports or activities? If YES, complete and attach the appropriate hazardous sports and activities questionnaire (4885).	☐ No ☐ Yes
8.	Has the Proposed Insured ever been convicted of impaired driving or had any moving violations? If YES, complete and attach the Driving Record Questionnaire (4018).	☐ No ☐ Yes
9.	Has the Proposed Insured ever applied for life insurance or reinstatement that has been declined, postponed, or modified (with higher premiums or exclusion)?	☐ No ☐ Yes
10.	In regards to the Proposed Insured, has a parent or brother or sister aged 17 years or less requested life insurance or is any of them insured for a lesser amount than the amount requested in this application? If YES, specify the family member, the amount of insurance in force or proposed amount, and the reason.	☐ No ☐ Yes
11.	Does the Proposed Insured live with a person other than a biological or adoptive parent? If YES, specify.	☐ No ☐ Yes
12.	Does the Proposed Insured's weight exceed the weight corresponding to his/her height in the following table?	☐ No ☐ Yes

I. FOR ALL "YES" ANSWERS *(for section G)*

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

J. DECLARATION OF INSURABILITY FOR WAIVER OF PREMIUM

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

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	(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
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
15.	Do you have any life insurance in force exceeding twenty (20) times your annual salary?	☐ No ☐ Yes
16.	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

K. FOR ALL "YES" ANSWERS *(for section 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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Youth Plus Data Collection Form

Age in months	Height				Weight			
	in		cm		lb		kg	
	Min	Max	Min	Max	Min	Max	Min	Max
15 days-1 mo	19	24	48	61	5	14	2	6
2	20	26	51	66	6	17	3	8
3	21	28	53	71	8	20	4	9
4	22	29	56	74	9	22	4	10
5	23	31	58	79	10	25	5	11
6 - 8	23	33	61	84	11	29	5	13
9 - 11	24	35	64	89	13	32	6	15
12 - 14	26	37	66	94	14	35	6	16
15 - 17	27	38	69	97	16	38	7	17
18 - 20	28	40	71	102	18	44	8	20
21 - 23	29	42	74	107	19	50	9	23

Current age
2 to 4 years of age

Height		Weight			
Ft/in	cm	lb		kg	
		Min	Max	Min	Max
2' 6"	76	19	39	9	18
2' 7"	79	19	41	9	19
2' 8"	81	20	43	9	20
2' 9"	84	20	45	9	20
2' 10"	86	21	47	10	21
2' 11"	89	22	50	10	23
3' 0"	91	24	53	11	24
3' 1"	94	25	56	11	25
3' 2"	97	26	59	12	27
3' 3"	99	27	62	12	28
3' 4"	102	29	65	13	30
3' 5"	104	30	67	14	30
3' 6"	107	31	69	14	31
3' 7"	109	32	71	15	32

Current age
5 to 8 years of age

Height		Weight			
Ft/in	cm	lb		kg	
		Min	Max	Min	Max
3' 2"	97	27	60	12	27
3' 3"	99	29	63	13	29
3' 4"	102	30	66	14	30
3' 5"	104	32	69	15	31
3' 6"	107	34	73	15	33
3' 7"	109	36	76	16	35
3' 8"	112	38	79	17	36
3' 9"	114	40	82	18	37
3' 10"	117	42	85	19	39
3' 11"	119	44	89	20	40
4' 0"	122	46	92	21	42
4' 1"	124	48	95	22	43
4' 2"	127	50	99	23	45
4' 3"	130	52	102	24	46
4' 4"	132	54	106	25	48
4' 5"	135	56	109	25	49
4' 6"	137	58	113	26	51
4' 7"	140	60	116	27	53
4' 8"	142	62	120	28	54

Current age
9 to 11 years of age

Height		Weight			
Ft/in	cm	lb		kg	
		Min	Max	Min	Max
3' 8"	112	35	77	16	35
3' 9"	114	37	81	17	37
3' 10"	117	40	85	18	39
3' 11"	119	42	89	19	40
4' 0"	122	45	93	20	42
4' 1"	124	47	97	21	44
4' 2"	127	50	102	23	46
4' 3"	130	52	106	24	48
4' 4"	132	55	110	25	50
4' 5"	135	57	114	26	52
4' 6"	137	60	118	27	54
4' 7"	140	62	123	28	56
4' 8"	142	65	127	30	58
4' 9"	145	67	131	30	59
4' 10"	147	70	135	32	61
4' 11"	150	72	139	33	63
5' 0"	152	75	144	34	65
5' 1"	155	77	148	35	67
5' 2"	157	80	152	36	69
5' 3"	160	83	157	38	71

Current age
12 to 14 years of age

Height		Weight			
Ft/in	cm	lb		kg	
		Min	Max	Min	Max
4' 4"	132	54	112	25	51
4' 5"	135	57	117	26	53
4' 6"	137	60	122	27	55
4' 7"	140	63	127	29	58
4' 8"	142	66	132	30	60
4' 9"	145	69	137	31	62
4' 10"	147	72	142	33	64
4' 11"	150	75	147	34	67
5' 0"	152	78	152	35	69
5' 1"	155	81	157	37	71
5' 2"	157	84	162	38	74
5' 3"	160	87	167	39	76
5' 4"	163	91	172	41	78
5' 5"	165	94	177	43	80
5' 6"	168	97	183	44	83
5' 7"	170	100	188	45	85
5' 8"	173	103	193	47	88
5' 9"	175	106	198	48	90
5' 10"	178	109	203	49	92
5' 11"	180	113	208	51	94
6' 0"	183	117	213	53	97
6' 1"	185	120	219	54	99

Current age – 15 to 17 years of age

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

Assumption Mutual Life Insurance Company, Doing Business Under the Name Assumption Life
P.O. Box 160/770 Main St., Moncton NB E1C 8L1 Tel. 506-853-6040/1-800-455-7337 Fax 1-855-230-2500

L. 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/2011)
- 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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P.O. Box 160/770 Main St., Moncton NB E1C 8L1 Tel. 506-853-6040/1-800-455-7337 Fax 1-855-230-2500

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

Assumption Mutual Life Insurance Company, Doing Business Under the Name Assumption Life
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