



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 the Assumption Life e-commerce process.

Policy option:  Individual  Spouse

This form is for:

Proposed Insured 1  Proposed Insured 2 (on spouse for rider Total Protection)

**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	<input checked="" type="checkbox"/> Email
Province of Birth	Date of Birth DD / MMM / YYYY (Example: 01/JAN/2014)
Country of Birth	Gender <input type="checkbox"/> M <input type="checkbox"/> F
Present residency status in Canada: <input type="checkbox"/> Canadian citizen <input type="checkbox"/> Permanent resident (landed immigrant) <input type="checkbox"/> 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: <input type="checkbox"/> No <input type="checkbox"/> Yes

**B. INSURANCE REQUESTED**

Total Protection \$ \_\_\_\_\_

Coverage Amount (\$5,000 to \$30,000 - 4 underwriting questions) or (\$30,001 to \$50,000 – 7 underwriting questions)

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

Annual  Monthly PAD Regular preauthorized debit (PAD) withdrawal day:  
 Semi- Annual  Coincides with day of application approval by Assumption Life  
 Quarterly  On the \_\_\_\_\_ (1<sup>st</sup> to 28<sup>th</sup>) 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.

# Total Protection Data Collection Form

## E. 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	_____	_____	_____	<input type="checkbox"/> Irrevocable <input type="checkbox"/> Revocable	_____
	_____	_____	_____	<input type="checkbox"/> Irrevocable <input type="checkbox"/> 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)*

	_____	_____	_____	<input type="checkbox"/> Irrevocable <input type="checkbox"/> Revocable <input type="checkbox"/> Irrevocable <input type="checkbox"/> Revocable	_____
	_____	_____	_____		_____

If a % is indicated the total must equal 100 %.

Assign a Trustee

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.

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

Owner:	<input type="checkbox"/> Proposed Insured 1	<input type="checkbox"/> Proposed Insured 2	<input type="checkbox"/> Other or Body Corporate (complete below)
Co-owner:	<input type="checkbox"/> Proposed Insured 1	<input type="checkbox"/> Proposed Insured 2	<input type="checkbox"/> Other (complete below)
Payer:	<input type="checkbox"/> Proposed Insured 1	<input type="checkbox"/> Proposed Insured 2	<input type="checkbox"/> Owner <input type="checkbox"/> Co-owner <input type="checkbox"/> Other (complete below)

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

Bank Name			
Bank Number	Branch number	<input type="checkbox"/> Savings	<input type="checkbox"/> 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

## Total Protection Data Collection Form

### 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/2014)

Copy address : Proposed Insured

1     2

Address

City

Province

Postal Code

Home Telephone

Work Telephone

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.

See data form for WP on Payer named afterward.

First Name

Last Name

Date of Birth \*\*    \_\_ / \_\_ / \_\_ \_\_  
DD      MMM      YYYY      (Example 01/JAN/2014)

Copy address : Proposed Insured

1     2

Address

City

Province

Postal Code

Home Telephone

Work Telephone

E-mail

Relationship with Proposed Insured \*\*

**\*\* These fields do not have to be completed for the payer.**

## G. DECLARATION OF INSURABILITY

Do not submit this application to Assumption Life if you answer YES to any of the following questions.

### Questions for any amount of sum insured.

1. Is this application intended to replace an existing individual life insurance?  No  Yes
2. Are you now hospitalized or bedridden to a clinic, a nursing home, a rest home, a hospital, a special care institution or at your residence?  No  Yes
3. Have you been treated for any type of cancer in the past three (3) years (other than basal cell carcinoma)?  No  Yes
4. Have you ever tested positive for HIV or undergone treatment (including medication) for AIDS or AIDS-related complex?  No  Yes

### Additional questions for sum insured exceeding \$30,000

5. In the past two (2) years, have you had any application for insurance rejected or postponed?  No  Yes
6. In the past two (2) years, have you been hospitalized for heart disease?  No  Yes
7. In the past five (5) years:
  - (a) Have you received a bone marrow transplant or an organ transplant (other than a corneal transplant) or were you advised that one was required?  No  Yes
  - (b) Have you been diagnosed with or treated for (including medication) amyotrophic lateral sclerosis (Lou Gehrig's disease), progressive bulbar paralysis, cor pulmonale or with an incurable terminal illness? N.B. Terminal illness means an incurable medical condition that will result in the death of the Insured within twelve (12) months.  No  Yes

## Total Protection Data Collection Form

### H. 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 29<sup>th</sup>, 30<sup>th</sup> or 31<sup>st</sup> where the date of issue shall be on the 28<sup>th</sup> day of the month.
- Date of issue requested (DD/MMM/YYYY): \_\_\_\_ / \_\_\_\_ / \_\_\_\_ (Example: 01/JAN/2014)
- 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.

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Name of representative (agent/broker) – Please print

