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	Email
Province of Birth	Date of Birth _ _ / _ _ _ / _ _ _ _ (DD MMM YYYY) (Example: 01/JAN/2014)
Country of Birth	Gender ☐ 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

☐ 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

☐ Semi- Annual

☐ Quarterly

Regular preauthorized debit (PAD) withdrawal day:

☐ Coïncides with day of application approuval 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.

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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				☐ 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 — 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:	☐ 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 Province
First Name	Postal Code
Last Name	Home Telephone
Date of Birth _ _/_ _ _/_ _ _ _ DD MMM YYYY (Example 01/JAN/2014)	Work Telephone
	E-mail
Copy address : Proposed Insured ☐ 1 ☐ 2	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 Province
First Name	Postal Code
Last Name	Home Telephone
Date of Birth ** _ _/_ _ _/_ _ _ _ DD MMM YYYY (Example 01/JAN/2014)	Work Telephone
	E-mail
Copy address : Proposed Insured ☐ 1 ☐ 2	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.	Are you currently hospitalized (admitted to a hospital), in a long-term care facility or nursing home, bedridden, or confined to a chair?	☐ No ☐ Yes
2.	Have you ever been diagnosed with, hospitalized for, or undergone treatment (including medication) for cystic fibrosis, HIV, AIDS, or AIDS-related complex?	☐ No ☐ Yes
3.	In the past two (2) years: (a) Have you been diagnosed with or hospitalized for a cerebrovascular accident (stroke)? (b) Have you been diagnosed with or hospitalized for chronic kidney disease or undergone dialysis? (c) Have you been diagnosed with, hospitalized for, or received radiation therapy for leukemia or cancer (other than basal cell carcinoma)? (d) Have you been prescribed a new medication or required a change in dosage in your medication relating to leukemia or cancer (other than basal cell carcinoma)?	☐ No ☐ Yes

Additional questions for sum insured exceeding $30,000

4.	Have you ever: (a) Been diagnosed with or undergone treatment (including medication) for amyotrophic lateral sclerosis (Lou Gehrig's disease), Alzheimer's disease, or dementia? (b) Been advised by a physician that you have an incurable terminal illness for which you have less than twelve (12) months to live?	☐ No ☐ Yes
5.	In the past five (5) years, 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
6.	In the past two (2) years, have you been diagnosed with or hospitalized for angina or a heart attack or undergone coronary angioplasty (with or without a stent insertion) or coronary artery bypass surgery?	☐ No ☐ Yes

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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 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)

- 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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Notes

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