Assumption Life

Give this copy to
Proposed Insureds and to Owners

# NOTICE

## RECORDS AND PERSONAL INFORMATION

In order to protect the confidentiality of your personal information, Assumption Life is responsible for ensuring that a file is established and retained according to the applicable rules, in the offices of Assumption Life or third parties acting on our behalf, in Canada or elsewhere, in which the information pertaining to your application for insurance, as well as the information pertaining to any insurance claim, will be placed. This personal information may be medical in nature or related to your lifestyle (driving record, pursuit of a hazardous sport, criminal record, etc.). When reviewing your insurance application or assessing a claim, we, our service providers or our reinsurers may consult any insurance file that we hold or that is held by other insurers or reinsurers with respect to any other insurance application or statement you may have made in the past.

For underwriting purposes or in the event of a claim, we could retain the services of an investigator in order to conduct an investigation in regard to you. This investigation may bear on your reputation, health, finances and lifestyle. In the course of this investigation, family members, friends and neighbors may be questioned about you.

We may also, for medical underwriting purposes, seek the assistance of a physician or a paramedical organization or a clinic in order to have you undergo a medical examination, X-rays, an electrocardiogram or to collect a blood, urine or saliva sample. The analysis will be used to determine the existence of various abnormalities such as diabetes, hepatic, kidney or liver disorder, bone disease, immune disorder, infections caused by the AIDS virus, and the presence of medication, drugs, nicotine or their metabolites and to determine cholesterol and blood lipid levels.

In the event of a claim, we may require a copy of your medical records. We may also require, in the event of a death claim, a copy of the police investigation report, coroner's report, or any other report that provides relevant information explaining the circumstances of your death.

When reviewing your insurance application or for underwriting purposes, your personal and medical information may be disclosed to your insurance agent if this information is necessary for the performance of the agent's duties. Only those employees or agents (including any reinsurer, health care professional or service provider) who need the personal information for the performance of their duties will have access to your file. If necessary, your personal information, including your medical information, may also be shared with your beneficiaries or personal representative in relation to a claim for a death benefit.

Your personal information may be securely used, stored or accessed in other countries and may be subject to the laws of those countries. We may have to disclose your personal information in response to a request from government authorities or a court order in these countries.

Assumption Life shall not communicate your personal information to a third party without your consent unless required to do so by law or ordered to do so by a court.

You are entitled to consult any personal information held in your file and, if applicable, to have it corrected by submitting a written request to the following address: ASSUMPTION LIFE, c/o Underwriting Department, P.O. Box 160, Moncton NB E1C 8L1. Telephone: 506-853-6040 or 1-800-455-7337 Fax: 855-230-2500.

## NOTICE FROM MIB, Inc. (MIB)

Information regarding your insurability will be treated as confidential. Assumption Life or its reinsurers may, however, make a brief report thereon to MIB, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or accident and sickness insurance coverage, or a claim for benefits is submitted to such company, MIB, upon request, will supply such company with the information in its files. As a U.S.-based company, MIB is bound by, and such personal information may be disclosed in accordance with, applicable U.S. laws.

Upon receipt of a request from you, MIB will arrange disclosure to you of any information it may have in your file. Please contact MIB at 416-597-0590. If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedure set forth in the U.S. federal Fair Credit Reporting Act. The address of MIB's information office is 330 University Avenue, Suite 501, Toronto ON M5G 1R7. To learn more about MIB, visit www.mib.com

Assumption Life, or its reinsurer(s), may also release any information in its file to other insurance companies to whom you may apply for life or accident and sickness insurance, or to whom a claim for benefits may have been submitted.



**Assumption Mutual Life Insurance Company, doing business under the name Assumption Life**
770 Main Street, P.O. Box 160 Moncton NB E1C 8L1 Tel. 506-853-6040 / 1-800-455-7337 Fax 855-230-2500

**Assumption Life**

# Declaration of Insurability

**for No Medical Whole Life – Immediate**
**and No Medical Term - Immediate**

**Policy/Contrat No.** ____________________

**Name of Insured** ______________________________ **Name of Owners (s)** ______________________________

**Application for** ☐ reinstatement ☐ delivery ☐ change from ______________________ to ______________________
☐ change from **smoker** to **non-smoker** ☐ other change ______________________________

**Do not submit this form if you have answered "yes" to any of the questions 2 through 18.**

| | | Yes | No |
|---|---|---|---|
| 1. | In the **past 12 months**, have you used any substance or product containing tobacco, nicotine, or marijuana mixed with nicotine or used e-cigarettes? | ☐ | ☐ |
| 2. | In the **past 90 days**, have you resided, on a temporary or permanent basis, in a long-term care facility or nursing facility or been hospitalized (admitted to a hospital), bedridden, or confined to a chair? | ☐ | ☐ |
| 3. | In the **past three (3) years**: | | |
| | (a) Have you had an amputation as a result of disease? | ☐ | ☐ |
| | (b) Have you been diagnosed with or hospitalized for chronic kidney disease or undergone dialysis? | ☐ | ☐ |
| | (c) Have you been diagnosed with or undergone surgery for an aneurysm? | ☐ | ☐ |
| | (d) Have you been diagnosed with, hospitalized for, or received radiation therapy for leukemia or cancer (other than basal cell carcinoma)? | ☐ | ☐ |
| | (e) 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? | ☐ | ☐ |
| | (f) Have you been prescribed a new medication or required a change in dosage in your medication relating to angina, a heart attack, leukemia, or cancer (other than basal cell carcinoma)? | ☐ | ☐ |
| 4. | In the **past three (3) years**, have you been diagnosed with or hospitalized for: | | |
| | (a) Chronic obstructive pulmonary disease (COPD) or emphysema that required the administration of oxygen? | ☐ | ☐ |
| | (b) Hepatitis B, hepatitis C, or cirrhosis of the liver? | ☐ | ☐ |
| | (c) Diabetic coma or hypoglycemic coma? | ☐ | ☐ |
| | (d) Cerebrovascular accident (stroke)? | ☐ | ☐ |
| | (e) Congestive heart failure or cardiomyopathy? | ☐ | ☐ |
| 5. | 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? | ☐ | ☐ |
| | (b) Have you been diagnosed with, hospitalized for, or undergone treatments (including medication) for cystic fibrosis, HIV, AIDS, or AIDS-related complex? | ☐ | ☐ |
| 6. | Have you ever been diagnosed with or treated for (including medication) amyotrophic lateral sclerosis (Lou Gehrig's disease), Alzheimer's disease, or dementia? | ☐ | ☐ |
| 7. | Have you been advised by a physician that you have an incurable terminal illness for which you have less than twelve (12) months to live? | ☐ | ☐ |
| 8. | Are you aware of any signs or symptoms for which you have not yet consulted a physician and/or a medical specialist or received treatment, or for which you have consulted a physician and/or medical specialist without having received a diagnosis? | ☐ | ☐ |
| 9. | Does your weight exceed the weight corresponding to your height in the following table? | ☐ | ☐ |

| Height | | Weight | | Height | | Weight | | Height | | Weight | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **ft/in** | **cm** | **lb** | **kg** | **ft/in** | **cm** | **lb** | **kg** | **ft/in** | **cm** | **lb** | **kg** |
| **4' 10"** | 147 | 188 | 85 | **5' 6"** | 168 | 235 | 107 | **6' 2"** | 188 | 286 | 130 |
| **4' 11"** | 150 | 193 | 88 | **5' 7"** | 170 | 240 | 109 | **6' 3"** | 191 | 294 | 134 |
| **5' 0"** | 152 | 199 | 90 | **5' 8"** | 173 | 246 | 112 | **6' 4"** | 193 | 301 | 137 |
| **5' 1"** | 155 | 204 | 93 | **5' 9"** | 175 | 254 | 115 | **6' 5"** | 196 | 307 | 140 |
| **5' 2"** | 157 | 212 | 96 | **5' 10"** | 178 | 259 | 118 | **6' 6"** | 198 | 315 | 143 |
| **5' 3"** | 160 | 218 | 99 | **5' 11"** | 180 | 265 | 120 | **6' 7"** | 201 | 323 | 147 |
| **5' 4"** | 163 | 223 | 101 | **6' 0"** | 183 | 272 | 124 | **6' 8"** | 203 | 329 | 150 |
| **5' 5"** | 165 | 228 | 104 | **6' 1"** | 185 | 280 | 127 | **6' 9"** | 206 | 338 | 154 |

| | | Yes | No |
|---|---|---|---|
| 10. | In the **past three (3) months**, have you required a new medication for high blood pressure or an increase in the dosage of any medication for high blood pressure? | ☐ | ☐ |




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| | | |
|---|---|---|
| 11. In the **past twelve (12) months**: | | |
| (a) Has your weight changed by more than 18.14 kg (40 lbs)(other than pregnancy related)? | ☐ | ☐ |
| (b) Have you been hospitalized for, did you require more than six (6) months off work for, or are you currently off work for any of the following conditions: depression, attempted suicide, attention-deficit disorder, attention-deficit hyperactivity disorder, burnout, chronic anxiety, chronic fatigue, eating disorders, schizophrenia, nervous breakdown, an emotional, a behavioral, psychological or nervous disorder? | ☐ | ☐ |
| 12. In the **past two (2) years**, have you had an application for individual life insurance declined or postponed by a company other than Assumption Life? | ☐ | ☐ |
| 13. In the **past three (3) years** have you required hospitalization for: transient ischemic attack (TIA or mini-stroke), heart murmur, chest pain, arrhythmia, asthma, chronic bronchitis, pulmonary sarcoidosis, tuberculosis, or diabetes? | ☐ | ☐ |
| 14. In the **past five (5) years**: | | |
| (a) Have you been diagnosed with or started treatment for convulsions, epilepsy, multiple sclerosis, heart disease, Parkinson's disease, muscular dystrophy, Huntington's disease, rheumatoid arthritis, or paralysis? | ☐ | ☐ |
| (b) Have you been diagnosed with or hospitalized for chronic kidney disease or undergone dialysis? | ☐ | ☐ |
| (c) Have you been diagnosed with or undergone surgery for an aneurysm? | ☐ | ☐ |
| (d) Have you been diagnosed with, hospitalized for, or received radiation therapy for leukemia or cancer (other than basal cell carcinoma)? | ☐ | ☐ |
| (e) 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? | ☐ | ☐ |
| (f) Have you been prescribed a new medication or required a change in dosage in your medication relating to angina, a heart attack, leukemia, or cancer (other than basal cell carcinoma)? | ☐ | ☐ |
| (g) Have you been diagnosed with or hospitalized for hemophilia? | ☐ | ☐ |
| 15. In the **past five (5) years**: | | |
| (a) Have you been diagnosed with or hospitalized for: hepatitis B, hepatitis C, cirrhosis of the liver, Crohn's disease, pancreatitis, ulcer or ulcerative colitis? | ☐ | ☐ |
| (b) Have you been diagnosed with or hospitalized for a cerebrovascular accident (stroke)? | ☐ | ☐ |
| (c) Have you required the administration of oxygen for any chronic respiratory condition? | ☐ | ☐ |
| (d) Have you used any drugs except as prescribed by a physician and other than marijuana? | ☐ | ☐ |
| (e) Due to alcohol or drug abuse, have you been advised by a health professional to reduce your consumption of alcohol or drugs or have you received advice or treatment for alcohol or drug abuse? | ☐ | ☐ |
| (f) Have you been charged with an alcohol-related or a drug-related driving offence or refused a breathalyzer? | ☐ | ☐ |
| 16. In the **next twelve (12) months**, do you expect or plan to: | | |
| (a) Engage in any hazardous sports or activities or make aerial flights other than as a passenger, a commercial pilot, or a crew member of a commercial flight or do you currently do so? | ☐ | ☐ |
| (b) Travel outside North America, the Caribbean, or Western Europe for more than six weeks or more than twice per year? | ☐ | ☐ |
| 17. Do you have: | | |
| (a) Diabetes **and** have been diagnosed with two (2) or more of the following diabetes complications: proteinuria (protein in the urine), neuropathy (numbness or weakness of the extremities), peripheral vascular disease (a circulation disorder), or retinopathy (eye disorder)? | ☐ | ☐ |
| (b) Any medical condition for which you are followed by a medical specialist at least every six (6) months **and** for which you require either treatment or medication, or regular testing at least every six (6) months? (Medical specialist does not include a general practitioner.) | ☐ | ☐ |
| 18. Biological family history: | | |
| (a) 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: type 1 diabetes, cancer, stroke, heart trouble, mental disorder that required hospitalization or who committed suicide? | ☐ | ☐ |
| (b) 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 18 (a)? | ☐ | ☐ |



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**AUTHORIZATION FOR REINSTATEMENT, DELIVERY AND CHANGE**

I request that Assumption Life reinstate and/or make the above change(s) to this contract. It is agreed that all information given in connection with this declaration of insurability is material to the consideration for acceptance by Assumption Life. It is also agreed that the reinstatement and change(s) requested in this declaration will take effect from the date of approval by Assumption Life provided overdue and/or required premiums and other indebtedness have been paid and the proof of health is found satisfactory to Assumption Life.

I understand that the reinstatement of the policy and of any riders will also result in the reinstatement of the two-year limitation period during which Assumption Life may void the contract if the Insured commits suicide or makes a false statement. If, within two years from the date of approval of reinstatement, the Insured commits suicide or if any statement in this declaration of insurability is false or if there is failure to disclose all facts material to the insurance, the reinstatement of the policy or rider shall be void, and any changes may be cancelled by Assumption Life.

I authorize any physician, health care professional, hospital, clinic or other medical or paramedical establishment, as well as any insurance company, MIB, Inc. (MIB), a credit agency, and any other organization, institution or person that holds records or information pertaining to me or my health status to exchange such records or information with Assumption Life or its reinsurers for claims adjudication purposes.

I authorize Assumption Life to retain the services of an investigator in order to conduct an investigation on me in the event of a claim. I understand that this investigation may bear on my reputation, health, finances and lifestyle.

In the event of a claim, I authorize any coroner, police force and any other agency that holds information regarding my death to communicate such information to Assumption Life and its reinsurers.

I acknowledge receipt of Assumption Life's **Notice for records and personal information** and from **MIB, Inc.** and agree with all its terms and conditions.

I authorize Assumption Life, or its reinsurers, to make a brief report on my personal health information to MIB.

**A COPY OF THIS AUTHORIZATION IS AS VALID AS THE ORIGINAL.**

Signed at ________________________________________, this____________day of ________________________________ 20 ______________

Insured's signature __________________________________________

Owner's signature*_____________________________________________ Title ______________________

(if other than proposed insured)

Agent's signature __________________________________________ Agent's code___________

Owner's signature*_____________________________________________ Title ______________________

* If the Owner is a Body Corporate (corporation, association, etc.), the signature of the authorized individuals and their title are required.



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