# No Medical Insurance Data Collection Form

## 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 policy ☐ Rider

This form is for:

☐ Proposed Insured 1 ☐ Proposed Insured 2

### 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/2011) |
| Country of Birth | Gender ☐ M ☐ F |
| Present residency status in Canada:<br>☐ Canadian citizen<br>☐ Permanent resident (landed immigrant)<br>☐ Other (specify) _____<br>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?*<br>Smoker: ☐ No ☐ Yes |

### B. INSURANCE REQUESTED

**No Medical Insurance Plus** ☐ Term ☐ Whole Life

Existing coverage of all products under the Non-Medical Insurance category * (if applicable) _____ $

**Sum insured requested +_____$**

Total insurance coverage (maximum allowed : $250,000) = _____$

Please complete medical questionnaire 1 – 17.

* No Medical Term Plus; No Medical Term; No Medical Whole Life Plus; No Medical Whole Life; No Medical Term – Immediate; No Medical Term – Deferred; No Medical Whole Life – Immediate; No Medical Whole Life – Deferred; Golden Protection; Golden Protection Deferred; Golden Protection Plus; Total Protection; InstaTerm: InstaTerm Deferred.

*Please note: if existing amount of coverage is not correctly specified, the sum insured requested may be reduced.*

**No Medical Insurance** ☐ Term ☐ Whole Life

Existing coverage of all products under the Non-Medical Insurance Category * (if applicable) _____ $

**Sum insured requested + _____ $**

Total insurance coverage (maximum allowed $150,000**)** = _____ $

Please complete medical questionnaire 1 – 8.

*Please note: If existing amount of coverage is not correctly specified, the sum insured requested may be reduced.*



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Additional Benefit Riders:

☐ Accidental Death – AD
(max. age of proposed insured is 55)* : $_____

Accidental Fracture Plus
(max. age of proposed insured is 69) :
☐ Insured ☐ Insured and Spouse ☐ Insured and Child
☐ Insured, Child and Spouse

☐ 1 unit
☐ 2 units

*AD rider amount cannot be greater than the initial sum insured.

☐ Child Insurance Benefit : ☐ $10,000 ☐ $20,000
(max. age of proposed insured is 60)

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

## 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. 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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## 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

### *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/2011) | 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/2011) | 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.***



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## G. DECLARATION OF INSURABILITY

Questions 1-8 : No Medical Whole Life **and** No Medical Term

Questions 1-17 : No Medical Whole Life Plus **and** No Medical Term Plus

| | **Proposed 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:<br>(a) Been diagnosed with, hospitalized for, or undergone treatment (including medication) for cystic fibrosis, HIV, AIDS, or AIDS-related complex?<br>(b) Been diagnosed with or undergone treatment (including medication) for amyotrophic lateral sclerosis (Lou Gehrig's disease), Alzheimer's disease, or dementia?<br>(c) 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 |
| **3.** 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 |
| **4.** In the **past three (3) years**:<br>(a) Have you been diagnosed with or hospitalized for a cerebrovascular accident (stroke)?<br>(b) Have you been diagnosed with or hospitalized for chronic obstructive pulmonary disease (COPD) or emphysema that required the administration of oxygen?<br>(c) Have you been diagnosed with or hospitalized for hepatitis B, hepatitis C, or cirrhosis of the liver?<br>(d) Have you been diagnosed with or hospitalized for diabetic coma or hypoglycemic coma?<br>(e) Have you been diagnosed with or hospitalized for congestive heart failure or cardiomyopathy? | ☐ No ☐ Yes |
| **5.** In the **past three (3) years**:<br>(a) Have you had an amputation as a result of disease?<br>(b) Have you been diagnosed with or hospitalized for chronic kidney disease or undergone dialysis?<br>(c) Have you been diagnosed with or undergone surgery for aneurysm?<br>(d) 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?<br>(e) Have you been diagnosed with, hospitalized for, or received radiation therapy for leukemia or cancer (other than basal cell carcinoma)?<br>(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)? | ☐ No ☐ Yes |
| **6.** 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? | ☐ No ☐ Yes |
| **7.** 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? | ☐ No ☐ Yes |



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| | |
|---|---|
| **8.** Does your weight exceed the weight corresponding to your height in the following table? | ☐ No ☐ Yes |

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

| | |
|---|---|
| **9.** Do you have a biological family member (father, mother, brother, sister), living or deceased, who was diagnosed before age 50 with Huntington's disease or polycystic kidney disease? | ☐ No ☐ Yes |
| **10.** Do you have:<br>(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)?<br>(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 (including medication), or regular testing at least every six (6) months? (Medical specialist does not include a general practitioner.) | ☐ No ☐ Yes |
| **11.** In the **past five (5) years**:<br>(a) Have you been diagnosed with or hospitalized for hemophilia, diabetic coma, or hypoglycemic coma?<br>(b) Have you been diagnosed with or hospitalized for hepatitis B, hepatitis C, cirrhosis of the liver, Crohn's disease, pancreatitis, or ulcerative colitis?<br>(c) Have you been diagnosed with or hospitalized for a cerebrovascular accident (stroke)?<br>(d) Have you been diagnosed with or hospitalized for chronic obstructive pulmonary disease (COPD) or emphysema that required the administration of oxygen | ☐ No ☐ Yes |



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| | |
|---|---|
| **12.** In the **past five (5) years**:<br>(a) Have you been diagnosed with, hospitalized for or started treatment (including medication) for convulsions, epilepsy, multiple sclerosis, Parkinson's disease, muscular dystrophy, Huntington's disease, rheumatoid arthritis, paralysis, congestive heart failure, or cardiomyopathy?<br>(b) Have you been diagnosed with or hospitalized for chronic kidney disease or undergone dialysis?<br>(c) 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?<br>(d) Have you been diagnosed with, hospitalized for, or received radiation therapy for leukemia or cancer (other than basal cell carcinoma)?<br>(e) 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)? | ☐ No ☐ Yes |
| **13.** In the **past five (5) years**:<br>(a) Have you used any drugs except as prescribed by a physician and other than marijuana?<br>(b) 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 (including medication) for alcohol or drug abuse?<br>(c) Have you been charged with an alcohol-related or a drug-related driving offence or refused a breathalyzer? | ☐ No ☐ Yes |
| **14.** In the **past three (3) years**, have you required hospitalization for any of the following conditions: heart murmur, chest pain, arrhythmia, asthma, chronic bronchitis, pulmonary sarcoidosis, tuberculosis, or two (2) or more transient ischemic attacks (TIAs or mini-strokes)? | ☐ No ☐ Yes |
| **15.** In the **past twelve (12) months**:<br>(a) Has your weight changed by more than 18.14 kg (40 lbs) (other than due to pregnancy)?<br>(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, or an emotional, behavioral, psychological or nervous disorder? | ☐ No ☐ Yes |
| **16.** 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? | ☐ No ☐ Yes |
| **17.** In the **next twelve (12) months**, do you expect or plan to:<br>(a) Engage in any hazardous sports or activities or make aerial flights other than as a passenger, commercial pilot, or crew member of a commercial flight or do you currently do so?<br>(b) Travel outside North America, the Caribbean, or Western Europe for more than six (6) weeks or more than twice per year? | ☐ 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/2011)

- 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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