Assumption Life
Since 1903

Reset

APPLICATION FOR CONVERSION OF SIMPLIFIED LIFE INSURANCE

☐ of Policy No. _____
☐ If more than one coverage in force on above policy, coverage to be converted: _____

1.INSURED

Insured 1

(a) Name _____
First name Last name Maiden name
(b) Address _____
P.O. Box No. & Street Apt. No.
_____
City/Town Province/Territory Postal Code
(c) Date of birth _____/_____/_____ d) Sex ☐ M ☐ F
Day Month Year
(e) Telephone residence (_____)_____
business (_____)_____
(f) E-mail _____

Insured 2

(a) Name _____
First name Last name Maiden name
(b) Address _____
P.O. Box No. & Street Apt. No.
_____
City/Town Province/Territory Postal Code
(c) Date of birth _____/_____/_____ d) Sex ☐ M ☐ F
Day Month Year
(e) Telephone residence (_____)_____
business (_____)_____
(f) E-mail _____

2. OWNER OF NEW POLICY

Please check ✓ the owner(s) below and complete the information.

☐ **Insured 1**: Social Insurance Number _____/_____/_____ (Required if the contract generates interest income or a taxable gain.)

☐ **Insured 2**: Social Insurance Number _____/_____/_____ (Required if the contract generates interest income or a taxable gain.)

☐ **Other** (Complete the following):

(a) Name _____ (b) Social Insurance Number _____/_____/_____
First name Last name Maiden name (Required if the contract generates interest income or a taxable gain.)
(c) Address _____
P.O. Box No. & Street Apt. No. City/Town Province/Territory Postal Code
(d) Date of birth ____/____/____ (e) Telephone residence (_____)_____ business (_____)_____
Day Month Year
(f) E-mail _____

3. BENEFICIARY

Insurance proceeds will be payable in equal shares to all primary beneficiaries named below who survive the Insured, unless a percentage is stated* (Total must be equal to 100%). If no primary beneficiary survives the Insured, the insurance proceeds will be divided equally among all designated contingent beneficiaries who survive the Insured.

INSURED 1

PRIMARY BENEFICIARY DESIGNATION

First Name	Last Name	Age	%*	Rev. / Irr.	Relationship to insured (In Quebec, relationship to owner)
				☐ ☐	
				☐ ☐	

CONTINGENT BENEFICIARY DESIGNATION (Applies only if all above-named Primary Beneficiaries die before the Proposed Insured 1)

First Name	Last Name	Age	%*	Rev. / Irr.	Relationship to insured (In Quebec, relationship to owner)
				☐ ☐	
				☐ ☐	

INSURED 2

PRIMARY BENEFICIARY DESIGNATION

First Name	Last Name	Age	%*	Rev. / Irr.	Relationship to insured (In Quebec, relationship to owner)
				☐ ☐	
				☐ ☐	

CONTINGENT BENEFICIARY DESIGNATION (Applies only if all above-named Primary Beneficiaries die before the Proposed Insured 2)

First Name	Last Name	Age	%*	Rev. / Irr.	Relationship to insured (In Quebec, relationship to owner)
				☐ ☐	
				☐ ☐	

Rev. (Revocable) or Irr. (Irrevocable): *Unless otherwise stipulated or not permitted by law, any beneficiary designation is revocable. If a beneficiary is named irrevocably, please note that his/her consent is required for any request that may affect his/her rights, including a change of beneficiary.*
In Quebec*, the designation of the owner's married or civil union spouse as beneficiary is irrevocable, unless otherwise stipulated.*
The policy does not confer any rights to contingent beneficiaries prior to the death of the primary beneficiaries.

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 client.services@assumption.ca

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4.REQUESTED INSURANCE

Insured 1	Insured 2
☐ Amount of term insurance to maintain $ _____*	☐ Amount of term insurance to maintain $ _____*
☐ Amount of insurance to convert $ _____	☐ Amount of insurance to convert $ _____
☐ No Medical Whole Life Plus (maximum age: 70)	☐ No Medical Whole Life Plus (maximum age: 70)
☐ Golden Protection (if age 71 and up – maximum amount: $50,000)	☐ Golden Protection (if age 71 and up – maximum amount: $50,000)

** If only part of the sum insured under the policy or rider indicated on page 1 is converted, you may choose to keep the policy in force for the remaining sum insured only if it is not lower than the minimum amount required by us for the policy.*

5. PREMIUM AND METHOD OF PAYMENT

Please send a copy of the premium calculation illustration page with this application.

Method of payment and amount of modal premium Please check one box: ☐ preauthorized debit (PAD) ☐ cheque/paid in cash (Head Office)

☐ **Monthly** $ _____ (PAD only) ☐ **Quarterly** $_____ ☐ **Semi-annual** $ _____ ☐ **Annual** $ _____

(a) Amount paid with application $ _____

(b) Payer (Check one): ☐ Insured 1 ☐ Insured 2 ☐ Owner (Other, as specified in section 2) ☐ Person named below

Name _____ Address _____

Telephone residence (_____)_____ business (_____)_____

**Insurance premiums may be subject to Provincial Sales Tax (PST)*

6. PREAUTHORIZED DEBIT AGREEMENT

Banking information	Please attach a blank cheque marked "VOID" or provide your banking information below if no cheque is available Name of Financial Institution _____ Address of Financial Institution _____ Branch No.: _____-_____-_____-_____-_____ Financial Institution No.: _____-_____-_____ Account No.: _____
Type of Service	☐ Personal – If debit is from a personal account ☐ Business – If debit is from a corporate account
Withdrawal Arrangements This preauthorized debit agreement is considered a variable one.	Frequency of withdrawals ☐ Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually Amount $_____ (subject to change) 1. I authorize Assumption Life to begin deductions, at any time, as per my instructions for regular recurring payments. 2. If a preauthorized debit is returned due to insufficient funds (NSF) in the account, Assumption Life will withdraw the related $25 fee from the same account, without notice. 3. I agree to the debiting of my account on the _____ (1st to 28th day of the month) or the next business day (Subject to change). 4. The first withdrawal from your account will be made the first business day following the date of policy issue, taking into account your financial institution's processing time. The next withdrawal date will be consistent with your PAD agreement. Please note that this could result in two premium withdrawals in the same month.
Waiver	**I waive the right to receive 10 days' notice of an increase or decrease in the amount of automatic withdrawal or a change in the date of withdrawal.***
Cancellation	You may cancel this preauthorized debit agreement at any time, subject to providing Assumption Life with 10 days' written notice. Contact your financial institution about your rights regarding cancellation. (A sample cancellation form is available at www.cdnpay.ca.)
Method of Payment	Any cancellation of this preauthorized debit agreement will not affect the agreement between you and Assumption Life whatsoever, so long as payment is provided by an alternate method.
Recourse & Reimbursement	You have certain recourse rights if any debit does not comply with this agreement. For example, you have the right to receive reimbursement for any debit that is not authorized or is not consistent with this PAD Agreement. To obtain more information on your recourse rights, contact your financial institution or visit www.cdnpay.ca.
Exclusive Rights	All amounts transferred from the preauthorized bank account for the premium payment are for the exclusive benefit of the owner of the insurance policy.
Date & Signature (If other than the Insureds or Owners of the new policy)	Date ____/____/____ Day Month Year Account Owner's Signature _____ Date ____/____/____ Day Month Year 2nd Account Owner's Signature _____

**Assumption Life will not increase your preauthorized debit or change your debit date after your insurance contract becomes effective without notifying you.*

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 client.services@assumption.ca

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8. SPECIAL INSTRUCTIONS

9. AUTHORIZATION AND SIGNATURES

I, the undersigned, hereby declare that all the information provided within is truthfully given to the best of my ability and knowledge and request that Assumption Life make the changes indicated.

By signing this application, the owners of the converted policy or rider acknowledge and accept that the conversion terminates the policy or rider indicated on page 1 even if only part of the sum insured is converted, unless otherwise specified in the above section 8.

Signed at _____, this _____ day of _____ 20 _____.

Signature of Insureds
(Legal guardian, if applicable)

_____
Insured 1

_____
Insured 2

Signature of Owners of this application (if other than Insureds) **and Signature of Owners of policy or rider converted if different**

_____ _____
Owner 1 Title*

_____ _____
Owner 2 Title*

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

Signature of the irrevocable beneficiaries of the converted policy of rider, if applicable.

_____ _____
Name: Name:

Name of agent 1 _____ **Code** _____ _____% **Signature** _____

Name of agent 2 _____ **Code** _____ _____% **Signature** _____

Total (must be equal to 100%) _____%

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