

Data Collection - 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 Assumption Life's electronic sales platform, Lia**

**Policy option:**     Individual                       Joint first-to-die                       Joint last-to-die

This form is for:

Proposed Insured 1     Proposed Insured 2 (*Joint first-to-die or last-to-die*)  
 Proposed Insured # \_\_\_ (WP/WPD on Owner ☞ complete sections A, G, H)     Proposed Insured # \_\_\_ (WP/WPD on Payer ☞ complete sections A, G, H)

**A. PROPOSED INSURED INFORMATION**

First Name	Address
Last Name	City
Previous Last Name	Province
Occupation *	Postal Code
* You must be specific, for example: "Retired teacher", "General Manager of a restaurant", "Human Resources Consultant".	
Name of Employer	Home Tel. ___ - ___ - ___      Work Tel. ___ - ___ - ___
Annual (Employment) Income	<input type="checkbox"/> E-mail _____
Province of Birth	Date of Birth    __/__/____ (Example: 01/JAN/2014)
Country of Birth	Sex <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    __/__/____	<i>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?</i>  Smoker: <input type="checkbox"/> No <input type="checkbox"/> Yes

**B. INSURANCE REQUESTED**

Essential Whole Life Life Pay                       Essential Whole Life 20-Year Pay                       Essential Whole Life Pay to age 65

Sum Insured (Min. \$10,000. – Max. \$4,000,000) \$ \_\_\_\_\_

**Additional Benefit Riders:**                      The maximum age for these riders is 55.

- DI based on loans (Loan repayment option)                      \$ \_\_\_\_\_ per month (*min. \$300, max. \$3 000 not exceeding 1% of the Essential Whole Life sum insured*)
- DI based on employment income (Income replacement option)    \$ \_\_\_\_\_ per month (*min. \$300, max. \$3 000 not exceeding 1% of the Essential Whole Life sum insured or 75% of the annual employment income divided by 12*)
- Critical illness rider ☞ Sum Insured (Min. \$10,000. – Max. \$25,000) \$ \_\_\_\_\_
- Accidental Death & Dismemberment (AD&D) \*\*: \$ \_\_\_\_\_                       Child Insurance Benefit:     \$10,000     \$20,000
- Waiver of premium upon disability (WP) \*\*\*                       Waiver of premium upon death (WPD) \*\*\*

\*\* AD&D Rider amount cannot be greater than the initial sum insured. AD&D is not available on joint policy.

\*\*\* If WP/WPD is for owner or payer, please use a separate form, complete only sections A, G, H and check only the WP and/or WPD under section "Insurance Requested"

<input type="checkbox"/> Accidental Fracture Plus: <input type="checkbox"/> Insured <input type="checkbox"/> Insured and Spouse <input type="checkbox"/> Insured and Child <input type="checkbox"/> Insured, Child and Spouse  <input type="checkbox"/> 1 unit <input type="checkbox"/> 2 units	Name of the Insured's spouse: _____ Complete name of the Insured's children: 1) _____ 2) _____ 3) _____ 4) _____ 5) _____
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## Essential Whole Life - Data Collection Form

### C. FLEXTERM LIFE INSURANCE RIDERS (max 5)

Insured # \_\_\_ Name \_\_\_\_\_  
 Insured # \_\_\_ Name \_\_\_\_\_  
 Insured # \_\_\_ Name \_\_\_\_\_  
 Insured # \_\_\_ Name \_\_\_\_\_  
 Insured # \_\_\_ Name \_\_\_\_\_

### YOUTH PLUS LIFE INSURANCE RIDERS (max 5)

Insured # \_\_\_ Name \_\_\_\_\_  
 Insured # \_\_\_ Name \_\_\_\_\_  
 Insured # \_\_\_ Name \_\_\_\_\_  
 Insured # \_\_\_ Name \_\_\_\_\_  
 Insured # \_\_\_ Name \_\_\_\_\_

↳ The Data Collection Form must be completed for the chosen product.

### D. 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

### E. 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.

### F. FAMILY DOCTOR

Does the Proposed Insured have a family doctor?     No     Yes  
 Family Doctor information not available at this time, to be provided at a later date  
 Family Doctor Name (Optional): \_\_\_\_\_  
 Family Doctor Address (Optional): \_\_\_\_\_

### G. 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 (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.



## Essential Whole Life - Data Collection Form

### I. DECLARATION OF INSURABILITY

- |            |   |  |
|------------|---|--|
| <b>1.</b>  | In the past five (5) years, have you applied for life insurance, critical illness insurance, disability insurance or reinstatement that has been declined, postponed, or modified (with higher premiums or exclusion)?  | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| <b>2.</b>  | In the past ten (10) years, have you been tested for (other than routine tests showing negative results), received treatments for, or had any known indication of:  |  |
|            | (a) Cancer or tumor?  | <input type="checkbox"/> No <input type="checkbox"/> Yes |
|            | (b) Convulsions, epilepsy, recurrent and severe headaches, paralysis, stroke, multiple sclerosis, Parkinson's disease, muscular dystrophy, Huntington's disease, Alzheimer's disease, dementia or any brain or neurological disorder, chronic fatigue, anxiety, depression, suicidal thoughts, attempted suicide, or other mental or nervous disorder?    | <input type="checkbox"/> No <input type="checkbox"/> Yes |
|            | (c) Heart murmur, high blood pressure, palpitations, chest pains, heart disease or any other disorder of the heart, blood vessels or blood, including abnormal cholesterol levels?  | <input type="checkbox"/> No <input type="checkbox"/> Yes |
|            | (d) Sleep apnea, respiratory or lung disorder, disorder of the stomach, liver, pancreas or intestines, including hepatitis B or C, or chronic diarrhea?   | <input type="checkbox"/> No <input type="checkbox"/> Yes |
|            | (e) Disorder of the kidneys, ureter, bladder (other than an uncomplicated urinary tract infection), breast, prostate, genital or reproductive organs, including any sexually transmitted infections?  | <input type="checkbox"/> No <input type="checkbox"/> Yes |
|            | (f) Disorder of the muscles, bones, back, neck, or joints, including fibromyalgia and arthritis, disorder of the eyes (other than corrective lenses), or disorder of the skin (other than acne or eczema)?  | <input type="checkbox"/> No <input type="checkbox"/> Yes |
|            | (g) Diabetes, disorder of the glands (other than controlled hypothyroidism) or lymph nodes, or other unexplained infections?  | <input type="checkbox"/> No <input type="checkbox"/> Yes |
|            | (h) AIDS (acquired immune deficiency syndrome), ARC (AIDS-related complex), AIDS virus antibody, or any other immunological disorder?   | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| <b>3.</b>  | Are you aware of any signs or symptoms for which you have not yet consulted a physician and/or a specialist or received treatment, or for which you have consulted a physician and/or a specialist without having received a diagnosis?   | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| <b>4.</b>  | In the past five (5) years, have you been convicted of impaired driving? If YES, complete and attach the Driving Record Questionnaire (4018).   | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| <b>5.</b>  | In the past five (5) years, have you been convicted of a crime or violation of any law or are you currently accused of a crime or violation of any law for which a verdict has not yet been rendered? If YES, complete and attach the Criminal Activity Questionnaire (5337).   | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| <b>6.</b>  | In the past five (5) years, have you used any drugs (including but not limited to marijuana, cocaine, LSD, amphetamines, hallucinogens, or unprescribed narcotics) or have you received advice or treatment for alcohol or drug abuse? If YES, complete and attach the appropriate questionnaire: Drug (3887), Alcohol (3876).                            | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| <b>7.</b>  | In the past five (5) years, have you been hospitalized, received treatments or been advised to receive treatment for any illness or disorder, other than discomfort, minor surgery or pregnancy?  | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| <b>8.</b>  | In the past two (2) years, have you received more than three (3) tickets for moving violations? If YES, complete and attach the Driving Record Questionnaire (4018).  | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| <b>9.</b>  | In the past two (2) years, have you engaged in any hazardous sports or activities or made aerial flights other than as a passenger or do you intend to engage in such sports, activities or flights? If YES, complete and attach the appropriate questionnaire: Scuba Diving (3908), Hazardous Sports and Activities (4885) or Aviation (3880).           | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| <b>10.</b> | Have you resided outside Canada in the past twelve (12) months or do you expect or plan to travel outside North America, the Caribbean, or Western Europe in the next twelve (12) months? If YES, specify the country, date, duration and, if applicable, purpose of travel or complete and attach the Foreign Travel and Residency Questionnaire (3893). | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| <b>11.</b> | 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: diabetes, cancer, stroke, heart trouble, mental disorder that required hospitalization or who committed suicide?   | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| <b>12.</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 11?   | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| <b>13.</b> | Has your weight changed by more than 9.08 kg (20 lbs) in the past year? If YES, state your current height and weight, your weight a year ago, the loss or gain and the reason.  |  |

## Essential Whole Life - Data Collection Form

14. Does your weight exceed the weight corresponding to your height in the following table?

No  Yes

Height		Weight		Height		Weight		Height		Weight	
Ft/in	cm	lb	kg	Ft/in	cm	lb	kg	Ft/in	cm	lb	kg
4' 10"	147	158	72	5' 6"	168	205	93	6' 2"	188	256	116
4' 11"	150	163	74	5' 7"	170	210	95	6' 3"	191	264	120
5' 0"	152	169	77	5' 8"	173	216	98	6' 4"	193	271	123
5' 1"	155	174	79	5' 9"	175	224	102	6' 5"	196	277	126
5' 2"	157	182	83	5' 10"	178	229	104	6' 6"	198	285	129
5' 3"	160	188	85	5' 11"	180	235	107	6' 7"	201	293	133
5' 4"	163	193	88	6' 0"	183	242	110	6' 8"	203	299	136
5' 5"	165	198	90	6' 1"	185	250	114	6' 9"	206	308	140

**Question below must be answered if the sum insured exceeds \$249,999.**

15. Do you have any life insurance in force exceeding twenty (20) times your annual salary?

No  Yes

### J. RIDERS - Questions below must be answered if one of the following additional benefit riders is chosen.

#### Waiver of Premium upon Disability

The waiver of premium upon disability is not renewable and terminates on the first of the following: on the expiry date of the policy's first term; on the rider anniversary nearest to the Insured's 60<sup>th</sup> birthday. The owner cannot be a Body Corporate (corporation, partnership, etc.).

I have read the above statement and confirm that the Owner understands the terms and conditions.

In the **past three (3) years**, have you:

- |   |  |
|---|--|
| (a) Been absent from work due to injury or illness for more than thirty (30) consecutive days?                    | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| (b) Applied for or received a disability benefit or compensation due to injury, illness or disability?            | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| (c) Consulted or received any treatment from a physiotherapist, massage therapist, chiropractor or acupuncturist? | <input type="checkbox"/> No <input type="checkbox"/> Yes |

#### DI based on loan or DI based on employment income

Answering "yes" to one of the following first two questions makes the Proposed Insured ineligible for disability income rider.

Are you currently unemployed?  No  Yes

By adding the number of hours worked in the **past three (3) months**, have you been working on average fewer than twenty (20) hours per week?  No  Yes

In the past three (3) years, have you:

- |   |  |
|---|--|
| (a) Been absent from work due to injury or illness for more than thirty (30) consecutive days?                    | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| (b) Applied for or received a disability benefit or compensation due to injury, illness or disability?            | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| (c) Consulted or received any treatment from a physiotherapist, massage therapist, chiropractor or acupuncturist? | <input type="checkbox"/> No <input type="checkbox"/> Yes |

#### Loan Information (Complete only if **DI based on loans** is chosen)

- The initial amortization period of the loan must be at least 15 years.
- The remaining loan period must be at least 5 years for the loan to be eligible for income disability.
- The expected start date for a real estate mortgage loan can be deferred up to six months from the application date.
- The personal line of credit must have a minimum credit limit of \$20,000.

Loan Description	Initial amortization period	Deferred Real Estate Mortgage Loan	Financial Institution	Initial loan amount or line of credit limit	Remaining loan period	Loan expiry date
	15 years or more?	If deferred, check and indicate expected start date of the loan		Approx.	Yrs Months	or MM YYYY
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Deferred _____ DD/MMM/YYYY				
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Deferred _____ DD/MMM/YYYY				
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Deferred _____ DD/MMM/YYYY				

## Essential Whole Life - Data Collection Form

### K. FOR ALL "YES" ANSWERS (for section H)

For all "Yes" answers, please give full details including name of the Proposed Insured, question number and name of physician and hospital involved.

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### L. CHILD'S INSURANCE BENEFIT (CIB)

Complete only if checked in the "INSURANCE REQUESTED" section.

List each natural or adopted child of Proposed Insured who is single and dependent upon this person for support:

	First and Last Name	Date of Birth day/month/year	Age	Sex	Height ft/in or m/cm	Weight lb-oz or kg-g
(a)	_____	_____	_____	_____	_____	_____
(b)	_____	_____	_____	_____	_____	_____
(c)	_____	_____	_____	_____	_____	_____
(d)	_____	_____	_____	_____	_____	_____
(e)	_____	_____	_____	_____	_____	_____

1. Were any of the children to be insured born prematurely or with an abnormality or disease?  No  Yes
2. Have any of the children to be insured been hospitalized or undergone any surgery?  No  Yes
3. Are any of the children to be insured taking medication, following a special diet or undergoing treatment for any condition?  No  Yes
4. Has any insurance on the children to be insured been refused, rated or issued with modifications?  No  Yes
5. Is this insurance intended to replace any other life insurance on any of the children to be insured?  No  Yes
6. Has any life insurance application been submitted to any other company within the past 12 months?  No  Yes

### M. FOR ALL "YES" ANSWERS (for section L)

For all "Yes" answers, please give full details including name of child, question number and name of physician and hospital involved.

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## Essential Whole Life - Data Collection Form

### N. 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)
- No conditional temporary life insurance is applicable if the requested date of issue is in the future.
  - 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

## Essential Whole Life - Data Collection Form

### QUESTIONS TO OBTAIN THE CONDITIONAL TEMPORARY INSURANCE AGREEMENT

**ONLY FOR FLEXOPTIONS, FLEXTERM, YOUTH PLUS, ESSENTIAL WHOLE LIFE, PARPLUS, PARPLUS JUNIOR, CRITICAL PROTECTION AND CRITICAL ILLNESS RIDER**

The questions featured inside the brackets below must be answered in order to qualify for the appropriate conditional temporary insurance.

		Proposed Insured 1	Proposed Insured 2	Proposed Insured 3
<div style="display: flex; flex-direction: column; align-items: center;"> <div style="margin-bottom: 20px;"> <span style="writing-mode: vertical-rl; transform: rotate(180deg); font-weight: bold;">CI &amp; Life</span> <div style="display: flex; align-items: center;"> <div style="border-left: 1px solid black; border-right: 1px solid black; height: 100px; margin: 0 5px;"></div> <div style="margin: 0 5px;"> <span style="font-size: 2em;">}</span> </div> <div style="writing-mode: vertical-rl; transform: rotate(180deg); font-weight: bold;">Life</div> </div> </div> <div> <span style="font-size: 2em;">}</span> </div> <div style="writing-mode: vertical-rl; transform: rotate(180deg); font-weight: bold;">CI</div> </div>	(a) In the last ten (10) years, have you been diagnosed with, received treatment for or had any indication or sign of: stroke, heart disease, tumor or cancer, HIV infection or AIDS?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
	(b) Have you ever had an application for life insurance declined, cancelled, modified (with higher premiums or an exclusion) or postponed?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
	(c) In the last three (3) months, have you been advised to undergo surgery or diagnostic testing or investigation that has not yet been completed (for a reason other than dental problems, pregnancy or childbirth)?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
	(d) Are you currently hospitalized or, in the last three (3) months, have you been admitted or advised to be admitted to a medical facility (except for childbirth)?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
	(e) Have you ever been diagnosed with, received treatment for or had any indication or sign of: cystic fibrosis, disease or disorder of the heart or blood vessels, chest pain, mini-stroke, stroke, tumor or cancer, diabetes, chronic liver, lung or kidney disease, HIV infection or AIDS, paralysis or blindness?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
	(f) Have you ever had an application for life insurance or critical illness insurance declined, cancelled, modified (with higher premiums or an exclusion) or postponed?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes

Eligibility for conditional temporary insurance is subject to the following terms and conditions:

- If the proposed insured requested **life insurance only**: answer **questions (a) to (d) above**.  
If the answer to one of these questions is YES or if one of these questions is not answered, the proposed insured will not qualify for conditional temporary life insurance.
- If the proposed insured requested **life insurance and the critical illness rider**: answer **questions (a) to (f) above**.  
If the answer to one of these questions is YES or if one of these questions is not answered, the proposed insured will not qualify for conditional temporary life insurance or conditional temporary critical illness insurance. **However**, if the answer to **questions (a) to (d)** is NO and if the answer to **questions (e) and/or (f)** is YES, the proposed insured will qualify for conditional temporary life insurance but will not qualify for conditional temporary critical illness insurance.
- If the proposed insured requested **Critical Protection critical illness insurance**: answer **questions (c) to (f) above**.  
If the answer to one of these questions is YES or if one of these questions is not answered, the proposed insured will not qualify for conditional temporary critical illness insurance.



