ParPlus junior

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 the Assumption Life e-commerce process.

Policy option: ☐ Individual

This form is for: ☐ Proposed Insured 1

☐ Proposed Insured #___ (WP/WPD on Owner ☞complete sections A, G, H, I) ☐ Proposed Insured #___ (WP/WPD on Payer ☞complete sections A, G, H, I)

A. PROPOSED INSURED INFORMATION

First Name	Address
Last Name	City
Previous Last Name	Province
Occupation ☐ Preschool ☐ Student ☐ Other: _____	Postal Code
Name of Employer	Home Tel._ _ _ - _ _ _ -_ _ _ _ Work Tel._ _ _ - _ _ _ -_ _ _ _
Annual (Employment) Income	E-mail
Province of Birth	Date of Birth _ _/ _ _ _/_ _ _ _ (DD MMM YYYY) (Example: 01/JAN/2011)
Country of Birth	
Present residency status in Canada: ☐ Canadian citizen ☐ Permanent resident (landed immigrant) ☐ Other (specify) _____ If other, indicate date of status _ _/ _ _ _/_ _ _ _ (DD MMM YYYY)	Sex ☐ M ☐ F

B. INSURANCE REQUESTED

☐ ParPlus Junior 20 Pay Sum Insured (Min. $5,000. – Max. $4,000,000) $ _____

Dividend Option: ☐ Cash ☐ Premium reduction ☐ Accumulation ☐ Paid Up additions ☐ Enhanced – 15-year guarantee

Additional Benefit Riders:

☐ **Youth Plus** - Sum Insured: ☐ $35 000 ☐ $52 500 ☐ $70 000 ☐ $87 500 ☐ $105 000 ☐ $122 500 ☐ $140 000 ☐ $157 500 ☐ $175 000

☐ Accidental Death & Dismemberment (AD&D)*: $_____

☐ Waiver of premium upon death (WPD) ** on Owner ☐ Waiver of premium upon death (WPD) ** on Payer

☐ Waiver of premium upon disability (WP) ** on Owner ☐ Waiver of premium upon disability (WP) ** on Payer

** AD&D Rider amount cannot be greater than the initial sum insured.*

*** If WP/WPD is for owner or payer, please use a separate form for Proposed Insured age 18 and older (ParPlus for adults), complete only sections A, G, H, I and check only the WP and/or WPD under section " Insurance Requested".*

C. FLEX TERM 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 _____

D. 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

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

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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	_____	___	___	☐ 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.

H. 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)

Indicate occupation _____ Social Insurance Number |___|___|___|___|___|___|___|___|___|

Verification of Identity by means of an original document. Check ✓ one box:

☐ Birth Certificate ☐ Driver's License ☐ Passport ☐ Other (Specify) _____

Reference Number _____ Place of Issue (Province/Country) _____

Banking Information ***(If possible, please include a personal cheque marked "VOID")***

Bank Name

Bank Number Branch Number ☐ Savings ☐ Chequing

Account Number

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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
First Name	Province
Last Name	Postal Code
Date of Birth _ _ / _ _ _ / _ _ _ _	Home Telephone Work Telephone
DD MMM YYYY (Example 01/JAN/2011)	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
First Name	Province
Last Name	Postal Code
Date of Birth * _ _ / _ _ _ / _ _ _ _	Home Telephone
DD MMM YYYY (Example 01/JAN/2011)	Work Telephone
Copy address : Proposed Insured ☐ 1 ☐ 2	E-mail
**** These fields do not have to be completed for the payer.***	Relationship with Proposed Insured *

Transaction on behalf of a third party

Have the owner(s) received money or instructions from anyone to purchase this life insurance? ☐ Yes ☐ No
If yes, will the owner(s) have to give a portion of the cash surrender value upon policy's termination? ☐ Yes ☐ No

Verification of owner and co-owner by means of an original document

Owner *(indicated above)*	**Co-owner** *(indicated above)*
SIN:	**SIN:**
Type of Identity:	Type of Identity:
Reference Number:	Reference Number:
Place of Issue - Province: Country:	Place of Issue - Province: Country:

I. DECLARATION OF INSURABILITY

1.	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)?	☐ No ☐ Yes
2.	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?	☐ No ☐ 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?	☐ No ☐ 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?	☐ No ☐ Yes
	(d) Sleep apnea, respiratory or lung disorder, disorder of the stomach, liver, pancreas or intestines, including hepatitis B or C, or chronic diarrhea?	☐ No ☐ 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?	☐ No ☐ 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)?	☐ No ☐ Yes

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	(g) Diabetes, disorder of the glands (other than controlled hypothyroidism) or lymph nodes, or other unexplained infections?	☐ No ☐ Yes
	(h) AIDS (acquired immune deficiency syndrome), ARC (AIDS-related complex), AIDS virus antibody, or any other immunological disorder?	☐ No ☐ Yes
3.	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?	☐ No ☐ Yes
4.	In the past five (5) years, have you been convicted of impaired driving? If YES, complete and attach the Driving Record Questionnaire (4018).	☐ No ☐ Yes
5.	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).	☐ No ☐ Yes
6.	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).	☐ No ☐ Yes
7.	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?	☐ No ☐ Yes
8.	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).	☐ No ☐ Yes
9.	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).	☐ No ☐ Yes
10.	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).	☐ No ☐ Yes
11.	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?	☐ No ☐ Yes
12.	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?	☐ No ☐ Yes
13.	Has your weight decreased by more than 10% in the past year? If YES, state your current height and weight, your weight a year ago, the loss and the reason.	☐ No ☐ Yes
14.	Does your weight exceed the weight corresponding to your height in the following table?	☐ No ☐ Yes
15.	In regards to the Proposed Insured, has a parent or brother or sister aged 17 years or less requested life insurance or is any of them insured for a lesser amount than the amount requested in this application? If YES, specify the family member, the amount of insurance in force or proposed amount, and the reason.	☐ No ☐ Yes
16.	Does the Proposed Insured live with a person other than a biological or adoptive parent? If YES, specify.	☐ No ☐ Yes
17.	Do you have any life insurance in force for an amount exceeding $100,000?	☐ No ☐ Yes

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ParPlus Junior Data Collection Form

Age in months	Height				Weight			
	in		cm		lb		kg	
	Min	Max	Min	Max	Min	Max	Min	Max
15 days-1 mo	**19**	**24**	**48**	**61**	5	14	2	6
2	**20**	**26**	**51**	**66**	6	17	3	8
3	**21**	**28**	**53**	**71**	8	20	4	9
4	**22**	**29**	**56**	**74**	9	22	4	10
5	**23**	**31**	**58**	**79**	10	25	5	11
6 - 8	**23**	**33**	**61**	**84**	11	29	5	13
9 - 11	**24**	**35**	**64**	**89**	13	32	6	15
12 - 14	**26**	**37**	**66**	**94**	14	35	6	16
15 - 17	**27**	**38**	**69**	**97**	16	38	7	17
18 - 20	**28**	**40**	**71**	**102**	18	44	8	20
21 - 23	**29**	**42**	**74**	**107**	19	50	9	23

Current age
2 to 4 years of age

Height		Weight			
Ft/in	cm	lb		kg	
		Min	Max	Min	Max
2' 6"	**76**	19	39	9	18
2' 7"	**79**	19	41	9	19
2' 8"	**81**	20	43	9	20
2' 9"	**84**	20	45	9	20
2' 10"	**86**	21	47	10	21
2' 11"	**89**	22	50	10	23
3' 0"	**91**	24	53	11	24
3' 1"	**94**	25	56	11	25
3' 2"	**97**	26	59	12	27
3' 3"	**99**	27	62	12	28
3' 4"	**102**	29	65	13	30
3' 5"	**104**	30	67	14	30
3' 6"	**107**	31	69	14	31
3' 7"	**109**	32	71	15	32

Current age
5 to 8 years of age

Height		Weight			
Ft/in	cm	lb		kg	
		Min	Max	Min	Max
3' 2"	**97**	27	60	12	27
3' 3"	**99**	29	63	13	29
3' 4"	**102**	30	66	14	30
3' 5"	**104**	32	69	15	31
3' 6"	**107**	34	73	15	33
3' 7"	**109**	36	76	16	35
3' 8"	**112**	38	79	17	36
3' 9"	**114**	40	82	18	37
3' 10"	**117**	42	85	19	39
3' 11"	**119**	44	89	20	40
4' 0"	**122**	46	92	21	42
4' 1"	**124**	48	95	22	43
4' 2"	**127**	50	99	23	45
4' 3"	**130**	52	102	24	46
4' 4"	**132**	54	106	25	48
4' 5"	**135**	56	109	25	49
4' 6"	**137**	58	113	26	51
4' 7"	**140**	60	116	27	53
4' 8"	**142**	62	120	28	54

Current age
9 to 11 years of age

Height		Weight			
Ft/in	cm	lb		kg	
		Min	Max	Min	Max
3' 8"	**112**	35	77	16	35
3' 9"	**114**	37	81	17	37
3' 10"	**117**	40	85	18	39
3' 11"	**119**	42	89	19	40
4' 0"	**122**	45	93	20	42
4' 1"	**124**	47	97	21	44
4' 2"	**127**	50	102	23	46
4' 3"	**130**	52	106	24	48
4' 4"	**132**	55	110	25	50
4' 5"	**135**	57	114	26	52
4' 6"	**137**	60	118	27	54
4' 7"	**140**	62	123	28	56
4' 8"	**142**	65	127	30	58
4' 9"	**145**	67	131	30	59
4' 10"	**147**	70	135	32	61
4' 11"	**150**	72	139	33	63
5' 0"	**152**	75	144	34	65
5' 1"	**155**	77	148	35	67
5' 2"	**157**	80	152	36	69
5' 3"	**160**	83	157	38	71

Current age
12 to 14 years of age

Height		Weight			
Ft/in	cm	lb		kg	
		Min	Max	Min	Max
4' 4"	**132**	54	112	25	51
4' 5"	**135**	57	117	26	53
4' 6"	**137**	60	122	27	55
4' 7"	**140**	63	127	29	58
4' 8"	**142**	66	132	30	60
4' 9"	**145**	69	137	31	62
4' 10"	**147**	72	142	33	64
4' 11"	**150**	75	147	34	67
5' 0"	**152**	78	152	35	69
5' 1"	**155**	81	157	37	71
5' 2"	**157**	84	162	38	74
5' 3"	**160**	87	167	39	76
5' 4"	**163**	91	172	41	78
5' 5"	**165**	94	177	43	80
5' 6"	**168**	97	183	44	83
5' 7"	**170**	100	188	45	85
5' 8"	**173**	103	193	47	88
5' 9"	**175**	106	198	48	90
5' 10"	**178**	109	203	49	92
5' 11"	**180**	113	208	51	94
6' 0"	**183**	117	213	53	97
6' 1"	**185**	120	219	54	99

Current age – 15 years of age and older

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

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J. 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.

K. 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)

- 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**.**

_____

Name of representative (agent/broker) – Please print

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QUESTIONS TO OBTAIN THE CONDITIONAL TEMPORARY INSURANCE AGREEMENT

ONLY FOR FLEXOPTIONS, FLEXTERM, YOUTH PLUS, 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
CI & Life / Life	(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?	☐No ☐Yes	☐No ☐Yes	☐No ☐Yes
CI & Life / Life	(b) Have you ever had an application for life insurance declined, cancelled, modified (with higher premiums or an exclusion) or postponed?	☐No ☐Yes	☐No ☐Yes	☐No ☐Yes
CI & Life / Life	(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)?	☐No ☐Yes	☐No ☐Yes	☐No ☐Yes
CI & Life / Life	(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)?	☐No ☐Yes	☐No ☐Yes	☐No ☐Yes
CI & Life / CI	(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?	☐No ☐Yes	☐No ☐Yes	☐No ☐Yes
CI & Life / CI	(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?	☐No ☐Yes	☐No ☐Yes	☐No ☐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.

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Notes

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