Critical PROTECTION

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 Assumption Life's electronic sales platform, Lia

This form is for:

☐ Proposed Insured 1 ☐ Proposed insured 2 (*Critical Protection rider*)

A. PROPOSED INSURED INFORMATION

First Name

Last Name

Previous Last Name

Province of Birth

Country of Birth

Present residency status in Canada:
☐ Canadian citizen
☐ Permanent resident (landed immigrant)
Critical Illness insurance is only available for Canadian citizens or Permanent residents.

Address

City

Province

Postal Code

Home Tel._ _ _ - _ _ _ -_ _ _ _ Work Tel._ _ _ - _ _ _ -_ _ _ _

E-mail

Date of Birth _ _/ _ _ _/_ _ _ _ (DD / MMM / YYYY) (Example: 01/JAN/2014)

Sex ☐ M ☐ F

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?

Smoker: ☐ No ☐ Yes

B. INSURANCE REQUESTED

Critical Protection ☐ 15 yrs ☐ 20 yrs ☐ 25 yrs ☐ Term to age 75 ☐ Term to age 75 - 20-year-pay

Sum Insured (Min. $10,000. – Max. $100,000) $ _____

Additional Benefit Riders:

☐ Return of premiums upon death

☐ Flexible return of premiums

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 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. 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): _____

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F. BENEFICIARY: The critical illness benefit is payable to the insured person. The Flexible return of premiums rider benefit, if selected, is payable to the policy owner. To name another beneficiary for those benefits, please complete the "Change of Beneficiary – Critical Protection" form.

UPON DEATH OF THE PROPOSED INSURED *(Complete only on data collection form for **Proposed Insured 1 and 2**)*
The beneficiary designation below is for the Return of premiums upon death rider only.

	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.

G. 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

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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
DD MMM YYYY (Example 01/JAN/2014)	Work Telephone
Copy address : Proposed Insured ☐ 1 ☐ 2	E-mail
	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/2014)	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 **

H. 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
	(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

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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 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. ☐ No ☐ Yes

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

15. Have you ever been tested for, received treatments for, or had any known indication of:

(a) Cancer, leukemia, lymphoma, tumour, cyst, nodule, or any abnormal growth? ☐ No ☐ Yes

(b) Hepatitis B or C, or colon polyps? ☐ No ☐ Yes

(c) Any breast disorder or abnormal breast discharge or change in appearance (other than surgery for cosmetic reasons)? ☐ No ☐ Yes

(d) Transient ischemic attack (TIA)? ☐ No ☐ Yes

16. Other than previously declared, in the past two (2) years, have you had any other disease, disorder, or abnormal test results that have not yet been disclosed? ☐ No ☐ Yes

I. 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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J. 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/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**.**

_____
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
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
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
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
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	(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	(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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