Assumption Life

P.O. Box 160/770 Main Street, Moncton, N.B.,Canada E1C 8L1
Tel.: 1-888-869-9797 Fax.: 1-855-401-9068

Reset

Employee(s) not actively at work

(ON THE CONTRACT'S EFFECTIVE DATE OR DURING ENROLLMENT)

Name of Employer (Policyholder) _____ Name of previous carrier _____

Name of Affiliates of Policyholder _____

Effective Date of Contract with Assumption _____ Previous Contract No. _____

Name of employee (Last name, surname)	**Last Day of Work**	**Reason for Absence** (In case of total disability, specify if waiver of premium is in effect, Yes or No)	"Y" or "N"	**Gross annual income at beginning of absence $**	**Benefits being covered by previous insurer**						
					L	OL	ADD	WI	LTD	H	D

I hereby declare that this report contains the names of all employees not actively at work as a result of an authorized absence or disability, who qualify for the group benefits being applied for.

_____ _____
Signature of employer Date

L: LIFE
OL: OPTIONAL LIFE
ADD: ACCIDENTAL DEATH AND DISMEMBERMENT
WI: WEEKLY INDEMNITY
LTD: LONG TERM DISABILITY
H: HEALTH
D: DENTAL