Transfer Authorization Request

Assumption Life

RESET

1. Client Identification (Account Holder / Policyholder / Entity Name)

Last Name or Entity Name | First Name | Date of Birth

Address | City | Province | Postal Code

Social Insurance No. | Telephone: Home | Office

JOINT ACCOUNT HOLDER NAME (IF APPLICABLE)

Last Name | First Name | Date of Birth

Address | City | Province | Postal Code

Social Insurance No. | Telephone: Home | Office

2. Receiving Institution Information

We accept transfers via FundServ A$M - Code ALM

ASSUMPTION MUTUAL LIFE INSURANCE COMPANY

Receiving Institution Name

770 Main Street | **Moncton** | **NB** | **E1C 8L1**

Address | City | Province | Postal Code

(506) 853-6040 | **(506) 853-9369** | |

Telephone | Fax | Group Plan No. (if applicable) | Client Account/Policy No.

Type of Investment:

☐ RSP ☐ LRSP ☐ LIRA ☐ RIF ☐ SRIF ☐ RLIF ☐ FHSA
☐ SRSP ☐ RLRSP ☐ NON-REG* ☐ PRIF ☐ LIF ☐ TFSA

**For non-registered transfers: please ensure your client is aware that there may be tax consequences.*

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3. Client Direction to Relinquishing Institution

Relinquishing Institution Name

Address | City | Province | Postal Code

Fax | Client Account/Policy No.

Transfer in cash (check one box only): ☐ Total* ☐ Partial* As listed below or on attached list.
**Please refer to statement in bold in Client Authorization section below.*

Investment Description	
Investment Amount $ or %	Client Account / Policy No.
Investment Description	
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Investment Description	
Investment Amount $ or %	Client Account / Policy No.

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4. Client Authorization

I hereby request the transfer of my investments as described above.

*I AUTHORIZE THE LIQUIDATION OF ALL OR PART OF MY INVESTMENTS AND AGREE TO PAY ANY APPLICABLE FEES, CHARGES OR ADJUSTMENTS.

Signature of Account Holder _____ Date _____

Signature of Irrevocable Beneficiary (if applicable) _____ Date _____
I consent to the transfer mentioned above.

FOR USE BY RELINQUISHING INSTITUTION ONLY

Type of Investment:

☐ RSP ☐ SRSP ☐ LRSP ☐ RLRSP ☐ LIRA ☐ LIF ☐ RLIF ☐ RIF - ☐ qualified or ☐ non-qualified
☐ SRIF ☐ PRIF ☐ TFSA ☐ FHSA ☐ NON-REG*

Minimum payment calculated with the spouse's age: ☐ Yes Date of birth: ____ / ____ / ____ ☐ No
Day Month Year

Spousal Plan: ☐ No ☐ Yes _____ | | | | | | | | | |
Name of spouse Social Insurance No.

Locked-in Funds: ☐ No ☐ Yes (Confirmation attached) $ _____ _____
Amount Governing Legislation

Contact Name _____ Telephone _____ Fax _____

Authorized Signature _____ Date _____

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