Assumption Life

GIVE THIS COPY TO PROPOSED INSUREDS AND OWNERS

RECORDS AND PERSONAL INFORMATION NOTICE

By submitting this insurance application to Assumption Life, you consent to the collection and use of some of your personal information as set out in this notice, including the sharing of your personal information with third parties. In this notice, the terms "us", "we", and "our" mean Assumption Life, its employees, representatives, and agents. The term "third parties" means the brokers, advisors, distribution partners, reinsurers, or service providers with whom we have a business relationship, including their employees, representatives, and agents.

Collection Purposes: You consent to the collection of your personal information to administer your product, now and in the future, on the terms set out below. We only collect personal information we require to provide the services associated with your product. These services include reviewing your application, underwriting, administration, claim handling, protection against fraud, mistakes, or false declarations, evaluating and improving our security and protection measures, and research and development.

Personal Information: The personal information collected may include your name, address, email address, date of birth, spouse's name, financial information, including banking information, your income and your social insurance number, medical information, or lifestyle information such as your driving record, your practice of dangerous sports, your criminal record, your credit report, etc. If you sign this application electronically, we also collect information to validate your signature, such as the time and place of the signature, and the IP address of the device used to provide your signature. We may collect your information through a third-party.

Use: Your personal information will only be used for the purposes for which it is collected. Only we and the third parties requiring your personal information to accomplish their functions, will have access to your personal information. You accept that we use your personal information to comply with all legal and regulatory requirements, to confirm your identity and the accuracy of the information you have provided, and to conduct searches to locate you and update your personal information.

Protection: To ensure the confidentiality of your personal information, we will establish and retain a file about you, in accordance with applicable law. We could store your personal information on third parties' servers located outside your province or outside Canada. If your personal information is stored outside Canada, it may be subject to the laws of that other country.

Communication to Third Parties: During the life of your product, we could be required to communicate your personal information with third parties to ensure we fulfill our obligations toward you or to allow such third parties to fulfill their obligations toward us. We have put in place service agreements with third parties with which we may share your personal information. These agreements provide for the protection of your personal information and for protection measures similar to those we have put in place. Without your consent, Assumption Life will only be able to share your personal information with third parties if we are required to do so pursuant to law or to a court order.

Specific Notices: During the review of your insurance application, including for the purposes of underwriting, we could retain the services of a medical doctor, a paramedical provider, or a clinic to conduct a medical examination, X-rays, an electrocardiogram or to collect a blood, urine or saliva sample. The analyses will be used to determine the existence of various abnormalities such as diabetes, hepatic, kidney or liver disorders, bone disease, immune disorder, infections caused by the AIDS virus, and the presence of medication, drugs, nicotine or their metabolites and to determine cholesterol and blood lipid levels. During the review of your insurance application or a claim, we could consult any insurance file in our possession or in the possession of other insurers or reinsurers regarding any other insurance request or claim you may have made in the past and we could retain an investigator to investigate you. This could concern your reputation, your health, your finances, and your lifestyle. During the review of a claim, we could require a copy of your medical file, including a copy of your file maintained by a provincial health insurance regime, such as the Régime de l'assurance-maladie du Québec, a copy of any police or coroner report, or any other information that could allow us to determine the circumstances of your death.

Your personal information, including your medical information, will be shared with your broker or advisor, your healthcare professionals, our reinsurers, our services providers, your beneficiaries, or your personal representative, if required for their respective purposes.

You are entitled to access any personal information held in your file and, if applicable, to have it corrected by call us at 506-853-6040 or 1-800-455-7337 or by submitting a written request to the following address: ASSUMPTION LIFE, c/o Underwriting Department, P.O. Box 160, Moncton NB E1C 8L1 or by email at ***selection@assomption.ca***

NOTICE FROM MIB, LLC. (MIB)

Information regarding your insurability will be treated as confidential. Assumption Life or its reinsurers may, however, make a brief report thereon to MIB, a membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or accident and sickness insurance coverage, or a claim for benefits is submitted to such company, MIB, upon request, will supply such company with the information in its files. As a U.S.-based company, MIB is bound by, and such personal information may be disclosed in accordance with, applicable U.S. laws.

Upon receipt of a request from you, MIB will arrange disclosure to you of any information it may have in your file. Please contact MIB at 866-692-6901. If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedure set forth in the U.S. federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree MA 02184-8734. To learn more about MIB, visit www.mib.com.

Assumption Life, or its reinsurer(s), may also release any information in its file to other insurance companies to whom you may apply for life or accident and sickness insurance, or to whom a claim for benefits may have been submitted.

Assumption Life

COPY TO BE REMITTED TO HEAD OFFICE

DELETE

SIGNATURE, DECLARATION & AUTHORIZATION FORM FOR THE ONLINE APPLICATION

APPLICATION NUMBER OR POLICY/CONFIRMATION NUMBER

The application number and policy/confirmation number are found in the Saved Applications section of Lia.

Number: _____ OR saved applications section of Lia: _____

1. PREAUTHORIZED DEBIT (PAD) AGREEMENT	
Withdrawal Arrangements *This preauthorized agreement is considered a variable one.*	1. I authorize Assumption Life to begin deductions, at any time, as per my instructions for regular recurring payments for the amount indicated in the application. 2. If a preauthorized debit is returned due to insufficient funds (NSF) in the account, Assumption Life will withdraw the related $25 fee from that same account, without notice. 3. I agree to the debiting of my account on the regular preauthorized debit (PAD) withdrawal day as indicated on the application or the next business day (Subject to change). 4. I accept that my bank account be debited for the first PAD as of the date of signing of the application, **if all preconditions for the conditional temporary insurance agreement are met**. Check the box if you refuse. ☐
Waiver	I waive the right to receive 10 days' notice of an increase or decrease in the amount of automatic withdrawal or a change in the date of the withdrawal.*
Cancellation	You may cancel this preauthorized debit agreement at any time, subject to providing Assumption Life with 10 days' written notice. Contact your financial institution about your rights regarding cancellation. (A sample cancellation form is available at www.cdnpay.ca.)
Method of Payment	Any cancellation of this preauthorized debit agreement will not affect the agreement between you and Assumption Life whatsoever, so long as payment is provided by an alternate method.
Recourse & Reimbursement	You have certain recourse rights if any debit does not comply with this agreement. For example, you have the right to receive reimbursement for any debit that is not authorized or is not consistent with this PAD Agreement. To obtain more information on your recourse rights, contact your financial institution or visit www.cdnpay.ca.
Exclusive Rights	All amounts transferred from the preauthorized bank account for the premium payment are for the exclusive benefit of the owner of the insurance policy.

* Assumption Life will not increase your preauthorized debit or change your debit date after your insurance contract becomes effective without notifying you.

NOTICE TO THE OWNER OF THE INSURANCE POLICY: Reimbursement of premiums, if any, shall be credited to the bank account from which premium payments were made, unless otherwise specified in the policy.

Underwritten by Assumption Mutual Life Insurance Company, doing business under the name Assumption Life
770 Main Street / P.O. Box 160 Moncton NB E1C 8L1 Tel.: 506-853-6040 / 1-800-455-7337 Fax.: 1-855-430-0591 E-mail: online.services@assumption.ca

2. DECLARATION OF PROPOSED INSUREDS AND OF OWNERS

- I have requested that the application be in English, and I request that all other related documents also be in English.
- I confirm that the information and answers that I have provided in the application and in any related document are complete and true and acknowledge that they constitute the basis for the contract.
- (For all proposed insureds having stated being non-smoker in the application) I hereby confirm that, in the past twelve (12) months I did not use any substance or product containing tobacco, nicotine, marijuana mixed with nicotine or e-cigarettes.
- I acknowledge that any misrepresentation may render the insurance coverage(s) voidable at Assumption Life's discretion within two years from the date of issue of the policy or rider(s) or date of reinstatement and that all fraud or any misrepresentation concerning the use of any substance or product containing tobacco, nicotine, marijuana mixed with nicotine or e-cigarettes shall render this contract automatically void and no claim for the sum insured will be payable.
- I understand that a telephone interview or other means may occasionally be used to complete the declaration of insurability, that such interview could be recorded, and that Assumption Life's acceptance of this application will also be based on those declarations.
- I understand that no insurance agent or person other than Assumption Life is authorized to modify, cancel or waive a question or provision of the application, nor a provision of the contract or of any rider or other document that is part of the contract. I understand that any notice to or knowledge of an insurance agent is not notice to or knowledge of Assumption Life unless stated in writing and made part of the application.
- I understand that the policy and any rider takes effect on the latest of the following dates:

  a. The date the application is approved without amendment or restriction by Assumption Life;

  b. The date of issue specified on the page titled "Policy Specifications" of the insurance contract when the application is approved without amendment or restriction by Assumption Life; or

  c. The date the proposed insured or proposed insureds, as the case may be, sign an amendment or restriction to the application at Assumption Life's request,

  provided that on that date:

  a. The first premium has been paid during the lifetime of all proposed insureds;

  b. No change has occurred with respect to the insurability of any proposed insured since the signing of the application; and

  c. Any information or answer provided in the application remains complete and true.
- I acknowledge and accept that Assumption Life will assume responsibility of the insurance risk only when the policy and rider(s) take effect, subject to the contract's limitations and exclusions.
- I acknowledge receipt of Assumption Life's Records and Personal Information Notice, and the Notice from MIB, LLC.
- In the event that the conditional temporary insurance agreement is available for the submitted application and I satisfy all preconditions, I acknowledge receipt and I accept all its terms and conditions.
- I agree to submit to medical exams, x-rays, and electrocardiograms, and to provide blood, urine and saliva samples, if required, for the purposes of underwriting.

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3. AUTHORIZATION OF PROPOSED INSUREDS

I authorize Assumption Life to collect, use, share and store my personal information, including my medical information, as set out in the Personal Information and Records Notice and the Notice from MIB, LLC included in this application. Without limiting the foregoing:

- I authorize any physician, health care professional, hospital, clinic or other medical or paramedical establishment, as well as any insurance company, MIB, a credit agency, and any other organization, institution or person that holds records or information pertaining to me, my health status, or to my children and their health status (when an insurance application on the life of a child is requested), including any authority administering a provincial health insurance program, such as the Régie de l'assurance-maladie du Québec, to exchange such records or information with Assumption Life or its reinsurers for underwriting and claims adjudication purposes.
- I authorize Assumption Life, or its reinsurers, to make a brief report on my personal health information to MIB, including the results of any medical exam or evaluation completed for the purposes of underwriting.
- In the event of a claim, I authorize any coroner, police force, or other agency that holds information regarding my death to communicate such information to Assumption Life and its reinsurers.

This authorization remains valid after my death.

I acknowledge that a reproduction of this authorization shall be as valid as the original.

4. NAME AND SIGNATURE OF THE PROPOSED INSUREDS, OWNERS, AND PAYERS

PROPOSED INSUREDS AGED 16 OR OLDER

*The **parent or legal guardian's signature is required** if the proposed insured is **under 16 years of age***

Proposed Insured 1

Name: _____ Signature: X _____

Signed in province: _____ Date: _____
(day/month/year)

Proposed Insured 2

Name: _____ Signature: X _____

Signed in province: _____ Date: _____
(day/month/year)

OWNERS

*If the owner is an **individual**, complete **section A** below. If the owner is a **body corporate (corporation, partners, etc.),** complete **section B only**.*

A. Name: _____ Signature: X _____

Signed in province: _____ Date: _____
(day/month/year)

Name: _____ Signature: X _____

Signed in province: _____ Date: _____
(day/month/year)

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B. **Body corporate (corporation, partners, etc.)**
FILL OUT ONLY IF THE OWNER OF THE POLICY IS A BODY CORPORATE

Name of the body corporate: _____

1. Name of person authorized to sign for the body corporate: _____

Title of person authorized to sign: _____

Signature: X _____ Signed in province: _____ Date: _____
(day/month/year)

2. Name of person authorized to sign for the body corporate: _____

Title of person authorized to sign: _____

Signature: X _____ Signed in province: _____ Date: _____
(day/month/year)

PAYERS (ACCOUNT HOLDERS) FOR PAD

*If two signatures are required on the bank account, both must appear in **section A** below. If Payer is a body corporate (corporation, partners, etc.), complete **section B** only.*

A. Name: _____ Signature: X _____ Date: _____
(day/month/year)

Name: _____ Signature: X _____ Date: _____
(day/month/year)

B. **Body corporate (corporation, partners, etc.)**
COMPLETE ONLY IF THE POLICY PAYER (BANK ACCOUNT HOLDER) FOR THE PAD IS A BODY CORPORATE
If two signatures are required on the bank account, both account holders must sign this authorization.

Name of the body corporate: _____

1. Name of person authorized to sign for the body corporate: _____

Title of person authorized to sign: _____

Signature: X _____ Date: _____
(day/month/year)

2. Name of person authorized to sign for the body corporate: _____

Title of person authorized to sign: _____

Signature: X _____ Date: _____
(day/month/year)

5. AGENT CODE, NAME, AND SIGNATURE

- The agent confirms having reviewed this declaration and authorization with the above-mentioned proposed insureds and owners and explained its content.
- The agent confirms having asked the questions listed in the application to the above-mentioned proposed insureds and owners and made sure that these were understood.
- In the case of an in person sale, the agent confirms having witnessed the signature of the proposed insureds, owners, and payers.

Code: _____ Name: _____ Signature: X _____

Date: _____
(day/month/year)

ATTENTION

Please send us a completed copy of this document by: **Fax**: 1-855-430-0591 or **Email**: online.services@assumption.ca

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