Assumption Life
Group Insurance

New Nouveau Brunswick

Living Benefit

Section 1 – To Be Completed by the Employee

First Name _____ Last Name _____ Policy 954

Address _____ City _____ Province _____ Postal Code _____

Employer _____ Date of Birth ___/___/_____ (DD/MM/YYYY) Telephone - Home _____ Telephone - Cell _____

I hereby authorize my employer, Plan Administrator, treating physician or other health care professionals to release to Assumption Life any medical or other information that may be necessary for the evaluation of this application. A copy of this authorization shall be as valid as the original

Employee's Signature _____ Date (DD/MM/YYYY) _____

Section 2 – To Be Completed by the Attending Physician

Terminal illness diagnosis: _____

The Group Life Insurance Plan provides for a living benefit where an incurable medical condition will result in the death of the insured within 12 months. To assist with the evaluation of this application, please indicate the anticipated life expectancy for your patient, from the date of this statement, given his or her medical condition: _____

Please include a copy of the complete medical file relating to this terminal illness.

Comments: _____

Attending Physician's Name (in print) _____

Complete Address _____

Telephone _____ Fax _____

Attending Physician's signature _____ Date (DD/MM/YYYY) _____

NOTE: THE PATIENT IS RESPONSIBLE FOR ANY FEES INCURRED TO COMPLETE THIS FORM.

Assumption Mutual Life Insurance Company, doing business under the name Assumption Life,
P.O. Box 160/770 Main St., Moncton NB E1C 8L1 Tel. 1-888-869-9797 Fax 506-853-5434 E-mail: lifedisability@assumption.ca