Assumption Life

Give this copy to Proposed Insureds

NOTICE

RECORDS AND PERSONAL INFORMATION

In order to protect the confidentiality of your personal information, Assumption Life is responsible for ensuring that a file is established and retained according to the applicable rules, in the offices of Assumption Life or third parties acting on our behalf, in Canada or elsewhere, in which the information pertaining to your application for insurance, as well as the information pertaining to any insurance claim, will be placed. This personal information may be medical in nature or related to your lifestyle (driving record, pursuit of a hazardous sport, criminal record, etc.). When reviewing your insurance application or assessing a claim, we, our service providers or our reinsurers may consult any insurance file that we hold or that is held by other insurers or reinsurers with respect to any other insurance application or statement you may have made in the past.

For underwriting purposes or in the event of a claim, we could retain the services of an investigator in order to conduct an investigation in regard to you. This investigation may bear on your reputation, health, finances and lifestyle. In the course of this investigation, family members, friends and neighbors may be questioned about you.

We may also, for medical underwriting purposes, seek the assistance of a physician or a paramedical organization or a clinic in order to have you undergo a medical examination, X-rays, an electrocardiogram or to collect a blood, urine or saliva sample. The analysis will be used to determine the existence of various abnormalities such as diabetes, hepatic, kidney or liver disorder, 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.

In the event of a claim, we may require a copy of your medical records. We may also require, in the event of a death claim, a copy of the police investigation report, coroner's report, or any other report that provides relevant information explaining the circumstances of your death.

When reviewing your insurance application or for underwriting purposes, your personal and medical information may be disclosed to your insurance agent if this information is necessary for the performance of the agent's duties. Only those employees or agents (including any reinsurer, health care professional or service provider) who need the personal information for the performance of their duties will have access to your file. If necessary, your personal information, including your medical information, may also be shared with your beneficiaries or personal representative in relation to a claim for a death benefit.

Your personal information may be securely used, stored or accessed in other countries and may be subject to the laws of those countries. We may have to disclose your personal information in response to a request from government authorities or a court order in these countries.

Assumption Life shall not communicate your personal information to a third party without your consent unless required to do so by law or ordered to do so by a court.

You are entitled to consult any personal information held in your file and, if applicable, to have it corrected by submitting a written request to the following address: ASSUMPTION LIFE, c/o Underwriting Department, P.O. Box 160, Moncton NB E1C 8L1. Telephone: 506-853-6040 or 1-800-455-7337 Fax: 855-230-2500.

NOTICE FROM MIB, Inc. (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 not-for-profit 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 416-597-0590. 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 330 University Avenue, Suite 501, Toronto ON M5G 1R7. 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 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 855-230-2500

Assumption Life
Since 1903

ERASE

Declaration of Insurability

Request for Change (Conversion)

Policy/Contrat No. _____

Name of Proposed Insured : _____ **Date of Birth :** _____

Prior to age 65, has any member of your biological family (father, mother, brother, sister), living or deceased, ever had:	- cancer - kidney trouble - Huntington's disease - a mental disorder that required hospitalization	- diabetes - heart trouble - stroke	- hemophilia - Steinert's disease - other hereditary disease	☐ Yes ☐ Non If yes, complete the following section for each person concerned.

Relationship	Disease/disorder (in case of cancer, please indicate type	Age at onset of illness	Age if living	Age at death	Cause of death
☐ father ☐ mother ☐ brother ☐ sister					
☐ father ☐ mother ☐ brother ☐ sister					
☐ father ☐ mother ☐ brother ☐ sister					

Name of family physician: _____

Date of last consultation, including reason and treatment received: _____

Height and Weight of Insured — **Height** : _____ft./in. _____m/cm **Weight :** _____ lb _____ kg

		Yes	No	Details of affirmative answers
1.	Currently :			
a)	Are you undergoing treatment (including medication), following a diet or under medical observation?	☐	☐	
b)	Are you aware of any symptoms for which you have not yet consulted a physician or received treatment, or for which you have consulted a physician without having received a diagnosis?	☐	☐	
c)	Have you been advised to have surgery or to have any analysis or diagnostic tests which have not yet been undertaken?	☐	☐	
2.	In the **past five (5) years**, have you:			
a)	Undergone a medical examination, consulted your family physician or other physician (other than for a routine exam)?	☐	☐	
b)	Been hospitalized or admitted to a hospital or other medical facility (other than for normal childbirth) or been advised that you needed to be?	☐	☐	
c)	Had an EKG, x-ray or other diagnostic test?	☐	☐	
d)	Ever applied for life insurance, health insurance, critical illness insurance, disability insurance or reinstatement that has been declined, postponed, rated or modified in any way?	☐	☐	
3.	Have you ever been tested for, received treatments for, or had any known indication of:			
a)	Heart murmur, high blood pressure, chest pains, palpitations, heart disease, stroke or any other disorder of the heart, blood vessels or blood?	☐	☐	
b)	Disorder of the nose or throat, asthma, bronchitis, emphysema, shortness of breath, sleep apnea or other respiratory disorders?	☐	☐	
c)	Disorder of the stomach, liver, pancreas or intestines, including hepatitis B or C, or chronic diarrhea?	☐	☐	
d)	Disorder of the kidneys, ureter, bladder, prostate, genital or reproductive organs, including any sexually transmitted infections?	☐	☐	
e)	Diabetes, disorder of the glands or lymph nodes, or other unexplained infections?	☐	☐	
f)	Disorder of the skin (other than acne or eczema), muscles, bones, back, neck, or articulations, including fibromyalgia?	☐	☐	
g)	Disorder of the eyes (other than corrective lenses), chronic fatigue, exhaustion, anxiety, depression, suicidal thoughts or other mental or nervous disorders, convulsions, epilepsy, headache, paralysis, degenerative disease, Parkinson's disease, Alzheimer's disease, dementia, multiple sclerosis, amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease) or any other brain or spinal cord disorder?	☐	☐	
h)	AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS-Related Complex), tested positive on the AIDS virus antibody test or any other immunological disorder?	☐	☐	
i)	Tumor, cancer, leukemia or other disorders not mentioned above?	☐	☐	

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4.	Tobacco, drug and alcohol			
a)	Have you ever used any drug other than as prescribed by a physician or received advice or undergone treatment for drug or alcohol abuse?	☐	☐	
b)	In the **last twelve (12) months**, have you used any substance or product containing tobacco, nicotine, or marijuana mixed with nicotine or used e-cigarettes? If yes, specify: kind, quantity and frequency.	☐	☐	
c)	Do you consume any alcoholic beverages? If yes, specify the number of units per day, week, month or year.	☐	☐	
d)	Have you ever consumed a greater amount of alcoholic beverages than your current consumption? If yes, specify the number of units and frequency. Explain the reasons for your reduction to the current consumption level and indicate how long since you reduced or stopped consumption.	☐	☐	
5.	Have you :			
a)	In the **past six (6) months**, been absent from work for more than seven (7) consecutive days due to an illness, accident or injury?	☐	☐	
b)	In the **past three (3) years**, engaged in any hazardous sports or activities or do you intend to do so? If yes, indicate the sport or activity practiced and the frequency.	☐	☐	
c)	In the **past ten (10) years**, been convicted of impaired driving, or in the **past three (3) years**, had two or more moving violations? If yes, specify the offences and date of each.	☐	☐	
d)	In the **past ten (10) years**, 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?	☐	☐	
e)	Resided outside Canada in the **last twelve (12) months** or have you any intention of traveling outside North America, the Caribbean or Western Europe? If yes, indicate the country, date, duration and, if applicable, the purpose.	☐	☐	

AUTHORIZATION FOR REINSTATEMENT, DELIVERY AND CHANGE

I request that Assumption Life reinstate and/or make the above change(s) to this contract. It is agreed that all information given in connection with this declaration of insurability is material to the consideration for acceptance by Assumption Life. It is also agreed that the reinstatement and change(s) requested in this declaration will take effect from the date of approval by Assumption Life provided overdue and/or required premiums and other indebtedness have been paid and the proof of health is found satisfactory to Assumption Life.

I understand that the reinstatement of the policy and of any riders will also result in the reinstatement of the two-year limitation period during which Assumption Life may void the contract if the Insured commits suicide or makes a false statement. If, within two years from the date of approval of reinstatement, the Insured commits suicide or if any statement in this declaration of insurability is false or if there is failure to disclose all facts material to the insurance, the reinstatement of the policy or rider shall be void, and any changes may be cancelled by Assumption Life.

I authorize any physician, health care professional, hospital, clinic or other medical or paramedical establishment, as well as any insurance company, MIB, Inc. (MIB), a credit agency, and any other organization, institution or person that holds records or information pertaining to me or my health status to exchange such records or information with Assumption Life or its reinsurers for claims adjudication purposes.

I authorize Assumption Life to retain the services of an investigator in order to conduct an investigation on me in the event of a claim. I understand that this investigation may bear on my reputation, health, finances and lifestyle.

In the event of a claim, I authorize any coroner, police force and any other agency that holds information regarding my death to communicate such information to Assumption Life and its reinsurers.

I acknowledge receipt of Assumption Life's **Notice for records and personal information** and from **MIB, Inc.** and agree with all its terms and conditions.

I authorize Assumption Life, or its reinsurers, to make a brief report on my personal health information to MIB.

A COPY OF THIS AUTHORIZATION IS AS VALID AS THE ORIGINAL.

Signed at _____, this_____day of _____ 20 _____

Insured's signature _____

Owner's signature*_____ Title _____

(if other than proposed insured)

Agent's signature _____ Agent's code_____

Owner's signature*_____ Title _____

* If the Owner is a Body Corporate (corporation, association, etc.), the signature of the authorized individuals and their title are required.

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