

PLAN WITH CONFIDENCE.



Golden Protection & Golden Protection Plus

Application Form



NOTICE

RECORDS AND PERSONAL INFORMATION

In order to protect the confidentiality of your personal information, Assumption Life will establish and retain a file 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.). We 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.

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 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.

Only those employees or agents (including any reinsurer or health care professional) who need the personal information for the performance of their duties will have access to your file. 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 / 770 Main Street, Moncton, N.B. E1C 8L1
Telephone: 506-853-6040/1-800-455-7337 Fax: 506-853-5459*

NOTICE FROM THE MEDICAL INFORMATION BUREAU

Information regarding your insurability will be treated as confidential. Assumption Life, or its reinsurer(s), may however make a brief report thereon or send a request to the Medical Information Bureau, a non-profit organization of life insurance companies that operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or if a claim for benefits is submitted to such company, the Bureau will, upon request, supply such company with the information in its files.

Upon receipt of a request from you, the Bureau will arrange disclosure to you of any information it may have in your file. If you question the accuracy of the information in the Bureau's file, you may have the information rectified. The address of the Medical Information Bureau is:

330 University Avenue, Suite 501, Toronto, Ontario, Canada M5G 1R7. Telephone number: 416-597-0590

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

ASSUMPTION LIFE RECEIPT FOR PREMIUM PAYMENT

Assumption Life acknowledges having received the sum of \$ _____ with Golden Protection and Golden Protection Plus application on the life of **Proposed insured 1** _____ **Proposed insured 2** _____.
The acceptance of this sum of money does not obligate Assumption Life to issue an insurance contract.

Signed at _____, this _____ day of _____, 20 _____

Agent's Signature x _____

The policy and any rider, when issued without amendment to the application, take effect on the date the application is approved by Assumption Life or on their date of issue specified on the page entitled "Policy Specifications" of the insurance contract, if later, provided that:

- (a) The first premium has been paid during the lifetime of all proposed insureds and has been paid on the date the application is approved by Assumption Life or on their date of issue specified in the Policy Specifications, if later; and
- (b) No change has occurred with respect to the insurability of any proposed insured from the signing of the application to the date the application is approved by Assumption Life or until their date of issue specified in the Policy Specifications, if later; and
- (c) Any information or answer provided in the application remains complete and true on the date the application is approved by Assumption Life or on their date of issue specified in the Policy Specifications, if later.

GOLDEN PROTECTION AND GOLDEN PROTECTION PLUS

Please complete all questions/statements in this application. (Please print using black or blue ink.)

☐ ADDITION TO POLICY/CONTRACT IN FORCE NO. _____

(For Head Office use only)

Policy/Contract No. _____

Client No. _____

1. PROPOSED INSURED

Proposed Insured 1 (a) Name _____
First Last Maiden Name (if applicable)

(b) Address _____
P.O. Box No. & Street Apt. No. City/Town Province Postal Code

(c) Date of Birth * ____/____/____ (d) Age ____ (at nearest birthday) (e) Sex ☐ M ☐ F (f) Place of Birth _____
Day Month Year Province/Country

(g) Telephone No. residence (____) _____ business (____) _____ (h) E-mail _____

(i) Present residence status in Canada: ☐ Canadian ☐ Landed Immigrant ☐ Other (specify) _____

Proposed Insured 2 (a) Name _____
First Last Maiden Name (if applicable)

(b) Address _____
P.O. Box No. & Street Apt. No. City/Town Province Postal Code

(c) Date of Birth * ____/____/____ (d) Age ____ (at nearest birthday) (e) Sex ☐ M ☐ F (f) Place of Birth _____
Day Month Year Province/Country

(g) Telephone No. residence (____) _____ business (____) _____ (h) E-mail _____

(i) Present residence status in Canada: ☐ Canadian ☐ Landed Immigrant ☐ Other (specify) _____

* Please verify the date of birth of the Proposed Insured by means of an original identification document.

2. OWNER

Please check ☒ the owner(s) below and complete the information. Do not complete this section if you have checked ☒ "ADDITION TO POLICY/CONTRACT IN FORCE" above.

☐ **Proposed Insured 1** Indicate occupation _____ Social Insurance Number |_|_|_|_|_|_|_|_|_|_|

☐ **Proposed Insured 2** Indicate occupation _____ Social Insurance Number |_|_|_|_|_|_|_|_|_|_|

☐ **Other (Complete the following)** (a) Name _____
First Last Relationship to Proposed Insured 1

(b) Address _____
P.O. Box No. & Street Apt. No. City/Town Province Postal Code

(c) Date of Birth ____/____/____ (d) Occupation _____ (e) Social Insurance Number |_|_|_|_|_|_|_|_|_|_|
Day Month Year

(f) Telephone No. residence (____) _____ business (____) _____ (g) E-mail _____

3. BENEFICIARY OF PROPOSED INSURED 1

Primary beneficiaries of Proposed Insured 1					Revocable or Irrevocable*		Outside Québec	In Québec
First Name	Last Name	Age	%	Rev.	Irrev.	Relationship to Proposed Insured 1	Relationship to Owner	
				<input type="checkbox"/>	<input type="checkbox"/>			
				<input type="checkbox"/>	<input type="checkbox"/>			
Total (Must be equal to 100%)								

Contingent Beneficiaries (Applies only if all above-named primary beneficiaries die before the Proposed Insured)					Outside Québec		In Québec
First Name	Last Name	Age	%	Rev.	Irrev.	Relationship to Proposed Insured 1	Relationship to Owner
				<input type="checkbox"/>	<input type="checkbox"/>		
				<input type="checkbox"/>	<input type="checkbox"/>		
Total (Must be equal to 100%)							

* In Québec, the designation of the owner's married or civil union spouse as beneficiary is irrevocable, unless otherwise stipulated. All other beneficiary designations are revocable unless otherwise stipulated.

The designation of an irrevocable beneficiary limits your rights under the contract and his/her consent will be required for all future transactions including changes of beneficiary.

4. BENEFICIARY OF PROPOSED INSURED 2

Primary beneficiaries of Proposed Insured 2				Revocable or Irrevocable *		Outside Québec	In Québec
First Name	Last Name	Age	%	Rev.	Irrev.	Relationship to Proposed Insured 2	Relationship to Owner
				<input type="checkbox"/>	<input type="checkbox"/>		
				<input type="checkbox"/>	<input type="checkbox"/>		
Total (Must be equal to 100%)							

Contingent Beneficiaries (Applies only if all above-named primary beneficiaries die before the Proposed Insured)						Outside Québec	In Québec
First Name	Last Name	Age	%	Rev.	Irrev.	Relationship to Proposed Insured 2	Relationship to Owner
				<input type="checkbox"/>	<input type="checkbox"/>		
				<input type="checkbox"/>	<input type="checkbox"/>		
Total (Must be equal to 100%)							

* See note on bottom of page 3

5. DECLARATION AS TO THE USE OF TOBACCO/NICOTINE

Have you, in the last 12 months, used any substance or product containing tobacco, nicotine or marijuana?
If the answer is "No", the premium class will be NON SMOKER. If the answer is "Yes", the premium class will be SMOKER.

Proposed Insured 1 ☐ Yes ☐ No Proposed Insured 2 ☐ Yes ☐ No

6. INSURANCE REQUESTED

If this application is an addition to an in force policy, the life insurance product must be the same as the policy.		Sum Insured	Annual Premium
Proposed Insured 1	<input type="checkbox"/> Golden Protection <input type="checkbox"/> Golden Protection Plus	\$	\$
	<input type="checkbox"/> Accidental fracture plus rider (complete appropriate application)		\$
Proposed Insured 2	<input type="checkbox"/> (Same insurance product as Proposed Insured 1)	\$	\$
	<input type="checkbox"/> Accidental fracture plus rider (complete appropriate application)		\$
Total		\$	\$

7. PREMIUM AND METHOD OF PAYMENT

Do not complete sections 7 and 8 if you have checked ☒ "ADDITION TO POLICY/CONTRACT IN FORCE" on Page 3.

Method of payment (Indicate the total premium for the contract according to the method of premium payment):

☐ Monthly \$ (See section 8 below) ☐ Annual \$ ☐ Semi-annual \$ ☐ Quarterly \$

(a) Amount paid with application \$

(b) Payer: ☐ Proposed Insured 1 ☐ Proposed Insured 2 ☐ Owner (other as specified in section 2) ☐ Other (Complete below)

Name Address

8. PREAUTHORIZED DEBIT (PAD) AGREEMENT (only if PAD was chosen in the application)

Banking Information

If the banking information was not provided in the application, please attach a blank cheque marked void.

Type of Service ☐ Personal - If debit is from a personal account ☐ Business - If debit is from a corporate account

Withdrawal Arrangements This preauthorized debit agreement is considered a variable one.

- 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.
- If a preauthorized debit is returned due to insufficient funds (NSF), Assumption Life is authorized to re-submit the payment. Any NSF charges incurred will be added to the subsequent preauthorized payment.
- I agree to the debiting of my account on the (1st to 28th day of the month) or the next business day (subject to change).
- If all preconditions for the conditional temporary life insurance agreement are met, I accept that my bank account be debited for the first PAD as of the date of signing of the application. Please check the box if you refuse. ☐

Waivers 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.cdnnpay.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.cdnnpay.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.

9. SPECIAL INSTRUCTIONS

10. INSURANCE REPLACEMENT

Proposed Insured 1	Is this application intended to replace an existing individual life insurance?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Proposed Insured 2	Is this application intended to replace an existing individual life insurance?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

If "Yes" complete and attach a disclosure statement.

If the individual life insurance being replaced is with Assumption Life, a written notice signed by the owner must be sent to Assumption Life in order to terminate the existing insurance.

11. DECLARATION OF INSURABILITY

Do not submit this application to Assumption Life if you answer "Yes" to any of the following questions.

	Proposed Insured 1	Proposed Insured 2
1. Are you presently hospitalized, in a nursing facility, bedridden or confined to a wheelchair, or have you been advised that this is required due to your present condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. In the past two years , have you had an application for life insurance (other than group insurance or group mortgage insurance) rejected or postponed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Within the past two years :		
(a) Did you have an amputation as a result of disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(b) Were you hospitalized for:		
(i) Heart failure?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(ii) Alzheimer's disease – dementia?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(iii) Cancer?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(iv) Leukemia?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(v) Chronic kidney disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(vi) Liver disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(vii) Diabetic coma or insulin shock?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(c) Were you diagnosed with any of the conditions listed in paragraph (b) above or did you receive medical or surgical treatments, or were you prescribed a new medication or a change in dosage for any of these conditions?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Within the past two years :		
(a) Were you hospitalized for:		
(i) Chronic respiratory condition that required the administration of oxygen?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(ii) Heart attack?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(iii) Coronary insufficiency?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(iv) Angina?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(v) Cerebrovascular accident (stroke)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(b) Were you diagnosed with any of the conditions listed in paragraph (a) above or were you prescribed a new medication or a change in dosage for angina following a deterioration of your angina condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Within the past five years :		
(a) Did you receive an organ transplant or a bone marrow transplant or were you advised that one was required due to your condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(b) Did you test positive for HIV or undergo treatments (including medication) for AIDS, AIDS-related complex or any other immune system disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(c) Were you diagnosed or treated (including medication) for an illness such as amyotrophic lateral sclerosis (Lou Gehrig's disease), progressive bulbar paralysis, cor pulmonale or any other incurable terminal illness?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(d) Were you informed that you had any of the conditions listed in paragraph (a), (b) or (c) above?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No



12. BODY CORPORATE OWNER

If the owner is a **Body Corporate** (corporation, partnership, association, etc.), complete below:

Type of business (agriculture, fishing, transport, professional services, etc.): _____ Registration number: _____

Is the Body Corporate active? ☐ Yes ☐ No Name of Body Corporate's directors (below):

1. _____ 2. _____ 3. _____ 4. _____

Indicate the names of the persons authorized to sign for the Body Corporate with their title:

Name _____ Title _____ Name _____ Title _____

13. DECLARATION, AUTHORIZATION, AND SIGNATURES OF PERSON INSURED AND OWNER

- I have requested that this application be in English and I request that all other related documents be in English also.
- I confirm that the information and answers contained in this 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 last twelve months I did not use any substance or product containing tobacco, nicotine or marijuana.
- I acknowledge that any misrepresentation may render the insurance coverage(s) voidable at Assumption Life's option within two years from the date of issue of the policy or rider(s) or date of reinstatement and that all misrepresentation concerning the declaration as to the use of any substance or product containing tobacco, nicotine or marijuana and fraud shall render this contract automatically void and no claim for the sum insured will be payable.
- I understand that no insurance agent or person other than Assumption Life is authorized to modify, cancel or waive a question or provision of this 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 this application.
- I understand that the policy and any rider, when issued without amendment to the application, take effect on the date the application is approved by Assumption Life or on their date of issue specified on the page entitled "Policy Specifications" of the insurance contract, if later, provided that:
 - The first premium has been paid during the lifetime of all proposed insureds and has been paid on the date the application is approved by Assumption Life or until their date of issue specified in the Policy Specifications, if later; and
 - No change has occurred with respect to the insurability of any proposed insured from the signing of the application to the date the application is approved by Assumption Life or until their date of issue specified in the Policy Specifications, if later; and
 - Any information or answer provided in the application remains complete and true on the date the application is approved by Assumption Life or on their date of issue specified in the Policy Specifications, if later.
- I acknowledge receipt of the Assumption Life's notice for records and personal information and from the Medical Information Bureau.**
- ☐ By checking here, I authorize Assumption Life to use my personal information in order to send me information on other products and services that might interest me.
- PREMIUM PAYMENT:** I acknowledge that any amount paid with this insurance application does not obligate Assumption Life to issue an insurance contract. 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.

AUTHORIZATION OF PROPOSED INSURED (1) AND (2)

I authorize any physician, health care professional, hospital, clinic or other medical or paramedical establishment, as well as any insurance company, the Medical Information Bureau, 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 to its reinsurers for claims adjudication purposes.

I authorize Assumption Life to retain the services of an investigator at the time of underwriting and during the claims process. This investigation, when necessary, may consist in obtaining information on my 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 that a reproduction of this authorization shall be as valid as the original.

Signed at _____, this _____ day of _____, 20 _____

Signature of Proposed Insureds

Signature of Owners* (if other than proposed insured)

(1) x _____ x _____ Title* _____

(2) x _____ x _____ Title* _____

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

Name and signature of account owners** (for a preauthorized debit agreement)

(ONLY FILL OUT IF DIFFERENT FROM THE PROPOSED INSURED OR OWNERS MENTIONED ABOVE)

If two signatures are required to sign on the account, both account owners must sign this Authorization.

Name _____ Signature x _____ Title** _____

Name _____ Signature x _____ Title** _____

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

☐ I confirm having provided and explained to my client an **Advisor disclosure statement** consistent with the requirements set out in the **Canadian Life and Health Assurance Association (CLHIA) Guideline G14**.

By signing below, the agent attests to the signature of all persons indicated above and also confirms that he or she has verified the date of birth of the Proposed Insureds and that they understand the language in which this application is written. If NO, give details in section 9 of this application.

Agent's signature x _____ Name of agent **Charles Taub**

Agent's code **AYXX(HUB)** Agent's telephone number **613-228-5433; 613-797-6866 (cell)**

Name of agency/firm **Life Insurance For Everyone**

(in block letters)

GOLDEN PROTECTION

Annual premium per \$1,000 (Age at nearest birthday)

Sum insured: from \$1,000 to \$50,000

Age	Non smoker		Smoker	
	M	F	M	F
40-45	24.49	19.06	33.98	26.98
46	24.70	19.23	35.70	27.22
47	24.92	19.39	37.43	27.45
48	25.13	19.56	39.15	27.69
49	25.34	19.73	40.87	27.92
50	25.56	19.89	42.60	28.16
51	26.95	21.26	44.95	29.62
52	28.35	22.63	47.30	31.09
53	29.75	24.00	49.65	32.55
54	31.15	25.37	51.99	34.02
55	32.55	26.74	54.34	35.48
56	34.65	28.24	58.02	37.53
57	36.74	29.75	61.70	39.57
58	38.84	31.25	65.37	41.62
59	40.93	32.76	69.05	43.67
60	43.03	34.26	72.73	45.71
61	46.57	36.51	77.53	48.63
62	50.10	38.76	82.33	51.54
63	53.64	41.01	87.13	54.45
64	57.18	43.26	91.94	57.36
65	60.71	45.51	96.74	60.27
66	65.80	48.93	103.41	64.41
67	70.88	52.34	110.08	68.54
68	75.97	55.75	116.75	72.68
69	81.05	59.16	123.42	76.82
70	86.13	62.58	130.09	80.95
71	93.54	67.50	139.26	86.40
72	100.95	72.43	148.43	91.84
73	108.36	77.36	157.60	97.29
74	115.77	82.28	166.77	102.73
75	123.17	87.21	175.94	108.18
76	135.45	95.34	187.64	118.41
77	147.73	103.48	199.34	128.64
78	160.00	111.62	211.05	138.87
79	172.28	119.75	222.75	149.10
80	184.55	127.89	234.46	159.33
81	203.10	144.65	261.83	174.59
82	221.64	161.40	289.20	189.85
83	240.19	178.16	316.57	205.10
84	258.73	194.92	343.94	220.36
85	277.27	211.68	371.32	235.61

GOLDEN PROTECTION PLUS

Annual premium per \$1,000 (Age at nearest birthday)

Sum insured: from \$1,000 to \$30,000

Age	Non smoker		Smoker	
	M	F	M	F
40-50	33.28	25.90	45.25	36.66
51	35.10	27.69	48.16	38.58
52	36.93	29.48	51.08	40.49
53	38.75	31.26	53.99	42.40
54	40.58	33.05	56.90	44.31
55	42.39	34.81	59.79	46.20
56	45.60	37.16	64.49	49.39
57	48.81	39.51	69.19	52.58
58	52.03	41.86	73.89	55.76
59	55.24	44.21	78.59	58.95
60	58.46	46.55	83.26	62.11
61	63.64	49.89	89.73	66.44
62	68.81	53.23	96.19	70.76
63	73.99	56.56	102.65	75.76
64	79.16	59.90	109.11	79.41
65	84.33	63.21	115.55	83.71
66	91.93	68.35	124.95	89.97
67	99.54	73.48	134.35	96.22
68	107.14	78.62	143.75	102.48
69	114.75	83.75	153.15	108.74
70	122.36	88.89	162.55	114.99
71	132.88	95.89	173.90	122.73
72	143.40	102.88	185.25	130.46
73	153.92	109.88	196.60	138.19
74	164.44	116.88	207.95	145.93
75	174.97	123.88	219.30	153.66
76	192.40	135.43	239.49	168.19
77	209.84	146.99	259.68	182.72
78	227.28	158.55	279.86	197.26
79	244.72	170.11	300.05	211.79
80	262.16	181.66	320.24	226.32

Annual Fees for Golden Protection and Golden Protection Plus

Annual policy fee: \$60

Annual policy fee for spouse rider: \$30

Minimum annual premium: \$150 per proposed insured

CASH VALUE PER \$1,000* - MALE AND FEMALE

Attained Age**	Value	Attained Age**	Value	Attained Age**	Value	Attained Age**	Value	Attained Age**	Value	Attained Age**	Value
43	19	53	39	63	81	73	169	83	299	93	579
44	21	54	42	64	88	74	182	84	319	94	609
45	23	55	45	65	95	75	195	85	339	95	639
46	25	56	48	66	102	76	208	86	369	96	679
47	27	57	51	67	109	77	221	87	399	97	719
48	29	58	54	68	116	78	234	88	429	98	819
49	31	59	57	69	123	79	247	89	459	99	919
50	33	60	60	70	130	80	260	90	489	100	1000
51	35	61	67	71	143	81	273	91	519		
52	37	62	74	72	156	82	286	92	549		

*N.B. The cash values start after three years.

They are adjusted in the following way:

duration 3: 25%

duration 5: 75%

duration 4: 50%

duration 6 and +: 100%

** Attained age on policy or rider anniversary

Example: Age at issue 60

CV before duration 3 = 0

CV duration 3 = 25% x 81 = 20

CV duration 4 = 50% x 88 = 44

CV duration 5 = 75% x 95 = 71

CV duration 6 = 102

CV duration 10 = 130

CV duration 20 = 260

GOLDEN PROTECTION PLUS

The sum insured increases on the policy or rider anniversary until the initial amount doubles or the insured attains age 100.

Year	Increasing sum insured	Year	Increasing sum insured	Year	Increasing sum insured	Year	Increasing sum insured
1	1000	10	1270	19	1540	28	1810
2	1030	11	1300	20	1570	29	1840
3	1060	12	1330	21	1600	30	1870
4	1090	13	1360	22	1630	31	1900
5	1120	14	1390	23	1660	32	1930
6	1150	15	1420	24	1690	33	1960
7	1180	16	1450	25	1720	34	1990
8	1210	17	1480	26	1750	35 and over	2000
9	1240	18	1510	27	1780		

Assumption Mutual Life Insurance Company, doing business under the name Assumption Life

Assumption Mutual Life Insurance Company
P.O. Box 160/770 Main St., Moncton, NB Canada E1C 8L1
Tel.: 506-853-6040 /1-800-455-7337 • www.assumption.ca



Mixed Sources
Product group from well-managed forests
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www.fsc.org
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