PLAN WITH CONFIDENCE.

Application Form

Assumption Life

4471-00A-MAR2010

LIVE WITH CONFIDENCE.

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 Total Protection 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.

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

Assumption Life

TOTAL PROTECTION

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
				❑	❑		
				❑	❑		
	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
				❑	❑		
				❑	❑		
	Total (Must be equal to 100%)						

* In Quebec, 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.

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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
				❏	❏		
				❏	❏		
	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
				❏	❏		
				❏	❏		
	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

		Sum Insured	Annual Premium
Proposed Insured 1	**TOTAL PROTECTION**	**$**	**$**
Proposed Insured 2	**TOTAL PROTECTION**	**$**	**$**
	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.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.

9. SPECIAL INSTRUCTIONS

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10. DECLARATION OF INSURABILITY

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

Questions for any amount of sum insured	Proposed Insured 1	Proposed Insured 2
1. Is this application intended to replace an existing individual life insurance?	❑ Yes ❑ No	❑ Yes ❑ No
2. Are you now hospitalized or bedridden in a clinic, a nursing home, a rest home, a hospital, a special care institution or at your residence?	❑ Yes ❑ No	❑ Yes ❑ No
3. Have you been treated for any type of cancer during the past three years?	❑ Yes ❑ No	❑ Yes ❑ No
4. Have you been informed that you have tested positive for the Human Immunodeficiency Virus (HIV) or have you been informed that you have Acquired Immune Deficiency Syndrome (AIDS) or any aids-related disease?	❑ Yes ❑ No	❑ Yes ❑ No
Additional questions for sum insured exceeding $30,000		
5. Within the past two years, have you had any application for insurance rejected or postponed?	❑ Yes ❑ No	❑ Yes ❑ No
6. Within the past two years, have you been hospitalized for heart disease?	❑ Yes ❑ No	❑ Yes ❑ No
7. 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?	❑ Yes ❑ No	❑ Yes ❑ No
b) 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?	❑ Yes ❑ No	❑ Yes ❑ No

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11. 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 ______________

12. 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:
  (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 until 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.
- **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 INSUREDS 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 (in block letters)

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)

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PREMIUMS AND CASH VALUES ON TOTAL PROTECTION

ANNUAL PREMIUM PER $1,000 (Age at nearest birthday)
Sum insured: $5,000 to $50,000

Age	Non smoker		Smoker		Age	Non smoker		Smoker	
	M	F	M	F		M	F	M	F
18	23.49	15.18	28.37	20.90	50	52.09	39.49	95.95	63.42
19	23.49	15.18	28.37	20.90	51	53.60	40.58	99.28	64.78
20	23.49	15.18	28.37	20.90	52	55.12	41.67	102.61	66.13
21	23.49	15.18	28.37	20.90	53	56.64	42.76	105.93	67.49
22	23.49	15.18	28.37	20.90	54	58.15	43.86	109.26	68.85
23	23.49	15.18	28.37	20.90	55	59.67	44.95	112.59	70.21
24	23.49	15.18	28.37	20.90	56	62.10	46.71	116.64	72.07
25	23.49	15.18	28.37	20.90	57	64.52	48.46	120.70	73.93
26	24.07	15.94	30.15	22.45	58	66.95	50.22	124.75	75.79
27	24.66	16.70	31.94	23.99	59	69.38	51.98	128.81	77.66
28	25.24	17.46	33.72	25.54	60	71.80	53.74	132.86	79.52
29	25.82	18.22	35.50	27.08	61	77.28	57.56	144.06	84.33
30	26.40	18.98	37.29	28.63	62	82.76	61.38	155.25	89.14
31	26.99	19.73	39.07	30.17	63	88.24	65.21	166.44	93.95
32	27.57	20.49	40.85	31.72	64	93.72	69.03	177.63	98.76
33	28.15	21.25	42.63	33.26	65	99.19	72.85	188.82	103.58
34	28.73	22.01	44.42	34.81	66	102.67	75.42	193.76	105.42
35	29.32	22.77	46.20	36.35	67	106.15	78.00	198.69	107.27
36	30.83	23.90	49.51	38.38	68	109.63	80.58	203.63	109.12
37	32.35	25.02	52.82	40.40	69	113.11	83.15	208.56	110.97
38	33.87	26.15	56.13	42.43	70	116.58	85.73	213.50	112.81
39	35.39	27.27	59.44	44.46	71	124.24	91.96	220.50	120.13
40	36.91	28.40	62.75	46.48	72	131.89	98.20	227.49	127.45
41	38.43	29.53	66.07	48.51	73	139.55	104.43	234.49	134.77
42	39.95	30.65	69.38	50.54	74	147.20	110.67	241.48	142.08
43	41.47	31.78	72.69	52.56	75	154.86	116.90	248.48	149.40
44	42.99	32.90	76.00	54.59	76	167.35	124.12	259.26	156.35
45	44.50	34.03	79.31	56.62	77	179.84	131.33	270.04	163.30
46	46.02	35.12	82.64	57.98	78	192.33	138.55	280.81	170.24
47	47.54	36.21	85.96	59.34	79	204.82	145.76	291.59	177.19
48	49.05	37.31	89.29	60.70	80	217.31	152.98	302.37	184.14
49	50.57	38.40	92.62	62.06	-	-	-	-	-

Annual policy fee: $80
Annual policy fee for spouse rider: $40

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
21	1	35	13	49	31	63	81	77	221	91	519
22	1	36	14	50	33	64	88	78	234	92	549
23	1	37	15	51	35	65	95	79	247	93	579
24	2	38	16	52	37	66	102	80	260	94	609
25	3	39	17	53	39	67	109	81	273	95	639
26	4	40	18	54	42	68	116	82	286	96	679
27	5	41	19	55	45	69	123	83	299	97	719
28	6	42	20	56	48	70	130	84	319	98	819
29	7	43	21	57	51	71	143	85	339	99	919
30	8	44	22	58	54	72	156	86	369	100	1000
31	9	45	23	59	57	73	169	87	399	-	-
32	10	46	25	60	60	74	182	88	429	-	-
33	11	47	27	61	67	75	195	89	459	-	-
34	12	48	29	62	74	76	208	90	489	-	-

*** 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 (Third anniversary) = 0

CV duration 3 = 25% x 81 = 20.25
CV duration 4 = 50% x 88 = 44.00
CV duration 5 = 75% x 95 = 71.25

CV duration 6 = 102
CV duration 10 = 130
CV duration 20 = 260

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

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