Assumption Life

Give this copy to Proposed Insured

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. 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 may require a copy of your medical records. We could also retain the services of an investigator in order to conduct an investigation in regard to you. This investigation may bear on your health, finances and lifestyle. In the course of this investigation, family members, friends and neighbours may be questioned about you.
In the event of a death claim, we could require 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 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

Statement of Health
(Group Insurance)

Please note: An incomplete questionnaire will delay the processing of the insurance application.

Employee Name ____________________ Date of Birth __________ (dd/mm/year) Address ____________________

Policy No. __________ Certificate No. __________ Home Telephone No. __________ Sex ☐ M ☐ F

If applying for Dependent coverage, please indicate dependent's name: __________ Date of Birth __________ (dd/mm/year)

Only the person to be insured must complete the Statement of Health.

1. (a) Height _________ ☐ ft/in ☐ m/cm (b) Weight __________ ☐ lb ☐ kg (c) Occupation __________

	Yes	No
2. Do you have a personal physician? If "yes", name and address __________	☐	☐
3. (a) Have any of your parents or siblings been diagnosed with heart disease, stroke or cancer before age 60? If yes, give details below.	☐	☐
(b) Have any of your parents or siblings been diagnosed with any hereditary disorder (such as Huntington's Chorea or polycystic kidney disease)?	☐	☐
4. Has your weight changed by more than 4.54 kg (10 lb) in the last year? If "yes", state the amount of gain or loss __________ and the reason __________	☐	☐
5. Within the past ten years, have you used any drugs except as prescribed by a physician or received advice or treatment for alcohol or drug abuse?	☐	☐
6. Are you currently taking any medication? If "yes", please indicate the reason, name, strength and quantity taken per month. __________	☐	☐
7. Have you, in the last 12 months, used any substance or product containing tobacco or nicotine?	☐	☐
8. Have you ever requested or received a pension, disability benefits, or compensation for any accident, injury or illness?	☐	☐
9. 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?	☐	☐

10. Have you ever consulted a physician (been treated for, or had any known indication of): (**Please circle applicable impairment(s)**)	Yes	No
(a) Chest pain, high blood pressure, high cholesterol, abnormal pulse, blood disorder, shortness of breath, palpitations, heart or circulatory disorder?	☐	☐
(b) Sciatica, muscle, bone or joint disease or disorder, loss of limbs or other deformity, fibromyalgia, chronic fatigue syndrome or paralysis?	☐	☐
(c) Convulsions, epilepsy, multiple sclerosis, stroke, dizziness, fainting, headaches or any other neurological disorders?	☐	☐
(d) a disorder of the kidneys, ureter, bladder, prostate, genital or reproductive organs, stomach, gallbladder, liver, pancreas or intestines?	☐	☐
(e) Cancer, tumor or other growth?	☐	☐
(f) Acquired immune deficiency syndrome (AIDS), Aids-related complex (ARC), other immune deficiency, or had a test indicating the presence of the AIDS virus or antibodies to the AIDS virus?	☐	☐
(g) Eye, ear, nose, throat or mouth disorder? (excluding corrective lenses)	☐	☐
(h) Asthma or other respiratory disorder, diabetes, back, neck or spinal disorder, arthritis or rheumatism, depression, anxiety or any other nervous or mental disorder, ulcer, colitis or Crohn's? **(If "yes", please complete the applicable questionnaire(s) on the back of this form.)**	☐	☐
11. Do you suffer from any physical impairment, disorder or disease not mentioned above?	☐	☐

Question number	Nature, date and duration of disease, injury or medical condition	Date		Treatment/ Results	Names and Addresses Doctors and Hospitals
		Began	Ended		

Declarations and Authorizations:

• I hereby confirm that the answers and other information provided in this Statement of Health are true and complete and acknowledge that they constitute the basis for my insurance coverage. • I understand that if any answer is incomplete or false, any insurance coverage granted may be voided. • I understand that I may be refused for insurance coverage in whole or in part if, in the opinion of Assumption Life, I am not insurable for all or part of that insurance coverage. • I understand that any changes in the accuracy of any of the statements and answers on the form between the date this form is signed and the date Assumption Life makes a decision must be reported to Assumption Life. • I understand that if I fail to do so, any insurance coverage granted may be voided. • I authorize Assumption Life to carry out tests, examinations, electrocardiograms, blood profiles, urine analyses and saliva test with a view to establishing my insurability in relation to my insurance application. • I confirm receipt of the "Notice from the Medical Information Bureau" and the notice regarding "Records and Personal Information". • I have retained a copy of this Statement of Health. • I authorize any insurer, reinsurer, healthcare provider, physician, health practitioner, pharmacist, hospital, health clinic, administrator of the group insurance plan, administrator of a government program or any other benefits program or agency, other medical or paramedical organization, the Medical Information Bureau or any service provider under the auspices of the group insurance plan to exchange with Assumption Life my personal information with respect to determining eligibility for benefits, group plan administration or evaluating any claim made thereunder. • This may include, but is not limited to, medical information. • A reproduction of this authorization shall be as valid as the original.

Note: In order to protect the confidentiality of your personal information, we recommend that you send us your form and medical information in an envelope marked "Confidential" to the following address: Assumption Life, c/o Underwriting Department, P.O. Box 160 / 770 Main Street, Moncton, N.B. E1C 8L1.

Date __________ **dd/mm/year**   __________ **Signature of the person to be insured (parent or legal guardian if Dependent is a minor)**

1. ASTHMA OR RESPIRATORY DISORDER

(a) Type: ☐ asthma ☐ bronchitis ☐ other ____________
(b) Severity: ☐ mild ☐ moderate ☐ severe
(c) Duration of attacks or episodes: ____________
(d) Frequency of attacks or episodes: ____________
(e) Date of last attack or episode: ____________
(f) Any hospitalization required? ☐ yes ☐ no dates ____________

(g) Type of treatment: ____________
(h) Any loss of time from work? ☐ yes ☐no
If "yes", give details and duration.

2. DIABETES

(a) Date of onset of diabetes: ____________
(b) Type of treatment: ☐ insulin ☐ oral medication ☐ diet
(c) Any history of diabetic comas or insulin reactions? ☐ yes ☐ no
If "yes", give details. ____________

(d) Do you follow a diabetic diet? ☐ yes ☐ no
(e) Have you ever had any of the following: ☐ yes ☐ no
Eye trouble, albumin/protein in the urine, numbness or a tingling sensation in the limbs.
If "yes", give full details including name and address of doctor(s) consulted for these conditions.____________

3. BACK, NECK OR SPINAL DISORDERS

(a) What area of the back was involved?
☐ neck ☐ middle (thoracic) ☐ lower (lumbo-sacral)
(b) What was the cause? ____________
(c) Date of first attack or episode: ____________
(d) Date of last attack or episode: ____________
(e) Frequency of attacks or episodes: ____________
(f) Type of treatment: ____________
(g) Any loss of time from work? ☐ yes ☐ no
If "yes", give date and duration. ____________

(h) Have you had any X-rays or other tests on your back? ☐ yes ☐ no
If "yes", give date, results and name of physician consulted.
(i) Has any surgery been performed or is any anticipated? ☐ yes ☐ no
If "yes", give date, results and name of physician consulted.
(j) What is your present condition regarding pain, limitation of movement and activity? ____________

4. ARTHRITIS OR RHEUMATISM

(a) Type ☐ rheumatoid ☐ osteoarthritis ☐ other ____________
(b) Date of onset: ____________
(c) Frequency of attacks or episodes: ____________
(d) Type of treatment: ____________
(e) Any loss of time from work? ☐ yes ☐ no
If "yes", give date and duration. ____________

(f) Name and address of physician(s) consulted.
(g) What joints are affected and present condition regarding pain, deformity, limitations of movement:

5. DEPRESSION, ANXIETY OR ANY OTHER NERVOUS OR MENTAL DISORDER

(a) Type of symptoms: ☐ weight loss ☐ depression ☐ insomnia ☐ suicidal thoughts ☐ fatigue ☐ nervousness ☐ anxiety ☐ phobia ☐ other ____________
(b) What was the cause? ____________
(c) Date of onset: ____________
(d) Frequency of attacks or episodes: ____________
(e) Type of treatment: ____________

(f) Any hospitalization required? ☐ yes ☐ no If "yes", date and duration. ____________
(g) Name and address of physician(s) consulted:
(h) Any time lost from work? ☐ yes ☐ no
If "yes", give date and duration. ____________

6. ULCER, COLITIS OR CROHN'S

(a) Type: 1. ulcer ☐ duodenal ☐ gastric ☐ esophagus
2. ulcerative ☐ colitis ☐ proctitis
3. ☐ Crohn's
(b) Frequency of attacks or episodes: ____________
(c) Date of last attack or episode: ____________
(d) Any hemorrhage (bleeding)? ____________
(e) Type of surgery (if required): ____________

(f) Type of treatment: ____________
(g) Any loss of time from work? ☐ yes ☐no
If "yes", give date and duration.

I, the undersigned, declare that the answers to the above questions are full, complete and true, are correctly recorded and are in continuance of and form part of an application for benefits.

Date **dd/mm/yy** ____________

____
Signature of the person to be insured (parent or legal guardian if Dependent is a minor)