



NOTICE

RECORDS AND PERSONAL INFORMATION

This notice applies to you, the member, and to your dependents for whom you have requested insurance.

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.

If family coverage is involved, statements and claim cheques, which may contain personal information pertaining to your spouse or dependents, will automatically be sent to you as the plan member. You must therefore notify your family members that you will be receiving this personal information.

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. 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 health care professional or pharmacist) 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 Group Insurance Department, P.O. Box 160 / 770 Main Street, Moncton, N.B. E1C 8L1.
Telephone: (506) 853-6040 / 1-800 455-7337 Fax: (506) 853-5434.



For Head Office use only

Effective Date:

Certificate No.:

Section A: To be Completed by Group Administrator

Employer, Policy Number, Occupation, Employee Classification, Hiring Date, Salary, Commission, Administrator's Signature, Date

Section B: To be Completed by Employee

Employee, Date of Birth, Gender, Language Preference, Address, Telephone No., Home, Work, E-mail

Bank Information (for claim reimbursement) Name of Financial Institution, Branch Address, Branch Number, Bank Number, Account Number

Dependent Information (Any employee with spouse and/or children will be granted dependent life coverage on his or her dependents if the plan offers this benefit.)

Table with columns: Last Name, First Name, Gender M/F, Date of Birth (Day, Month, Year), **Dependent Status (E or S)

* If common-law spouse, please specify date cohabitation began. **Dependent Status: E - Education, S - Special

Health Insurance (if provided for under your plan) Dental Insurance (if provided for under your plan)

Health Insurance options: Single, Family, Couple, Single-Parent, Coordination of Benefits. Dental Insurance options: Single, Family, Couple, Single-Parent, Coordination of Benefits

Waiver of Benefits

Comment: All benefits under your group insurance plan are mandatory. However, you may waive the health and dental insurance benefits if you have similar coverage under your spouse's plan.

I understand the terms and conditions of the group insurance plan that is being offered, but I waive the following benefits:

Health Insurance

Dental Insurance

Name of Spouse's Insurer: _____ Policy Number: _____

If coverage under your spouse's plan is discontinued, you will have a 31-day period in which to submit an application for coverage. After this date, you and your dependents must submit proof acceptable to Assumption Life in order to be covered. Upon approval of your membership, if need be, the dental insurance benefit will be limited.

Request for Complementary Insurance (if provided for under your plan)

Optional Life Insurance \$ _____ Optional Life Insurance for Spouse \$ _____

Beneficiary Designation:

Primary Beneficiary	Relationship	Date of Birth	Percentage
Contingent Beneficiary (in the event of the primary beneficiary's death)	Relationship	Date of Birth	Percentage

If the beneficiary is a minor, please designate a trustee: _____

Relationship to employee: _____

* You may change this beneficiary designation by submitting a written notice to Assumption Life. A form for this purpose is available from your group administrator or on our Web site.

Declarations and Authorizations

I confirm that the information and answers that I have provided in this document are true and complete.

I attest to having received my dependents' consent (spouse and/or children) in order to enrol in this group insurance plan in their name. (Only applicable if you have requested coverage for you spouse and/or children).

I authorize my employer to withdraw the necessary contributions from my salary.

I authorize Assumption Life to deposit all my claim reimbursements to the designated bank account.

I authorize any insurer, reinsurer, physician, health care provider or professional, pharmacy, hospital, clinic, my group insurance administrator, administrator of a government or other fringe benefits program, organization, or service provider within the scope of my group insurance plan that holds information pertaining to me or my dependents to exchange such records or information with Assumption Life for the purposes of determining eligibility to benefits and for plan administration or claims analysis purposes. This information may be of a medical or other nature.

In the event of death, I authorize any beneficiary, heir or executor to provide Assumption Life or its reinsurers with all information or authorizations deemed necessary for claims adjudication purposes and for obtaining supporting documents. I authorize any coroner, police force or toxicologist that holds my personal information, including any accident and police investigation reports regarding a claims analysis following death, disability or dismemberment, to exchange such information with Assumption Life. I also authorize the communication of my personal information (other than of a medical nature) to any private investigator and authorize this private investigator to communicate any information collected regarding me to Assumption Life.

This authorization is valid for the purposes of this contract, its modification, its extension or its reinstatement.

I acknowledge that a reproduction of this authorization shall be as valid as the original.

I authorize Assumption Life to use my personal information in order to send me information on other products and services that might interest me. If not, please check the following: I do not authorize this use.

Employee's Signature

Date