



# Assumption Life

P.O. Box 160/770, Main Street, Moncton, N.B., Canada E1C 8L1  
Tel: 506 853-6040 Fax: 506 853-5459

# Total Protection Application

Policy \_\_\_\_\_

### 1. Proposed insured (please print)

First Name \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_  
No. \_\_\_\_\_ Street \_\_\_\_\_  
City \_\_\_\_\_ Postal Code \_\_\_\_\_

### 2. Date of birth

Day / Month / Year Age \_\_\_\_\_ Sex \_\_\_\_\_

### 3. Insurance on Proposed Insured

Total Protection Amount \$ \_\_\_\_\_

### 4. Dividend Option

Cash  Reduced Premiums  
 Accumulation

### 5. Premium Payable

Annually  COM

### 6. Premium Notices

Insured at residence \*Other (give name and address below)  
\_\_\_\_\_  
\_\_\_\_\_

### 7. Social Insurance Number \_\_\_\_\_

### 8. Owner

Proposed Insured  Other (give name & address)  
\_\_\_\_\_  
\_\_\_\_\_

### 9. Beneficiary

First Name \_\_\_\_\_ Age \_\_\_\_\_ Relationship \_\_\_\_\_

Contingent Name \_\_\_\_\_ Age \_\_\_\_\_ Relationship \_\_\_\_\_

### 10. Premium paid \$ \_\_\_\_\_

11. Agent code \_\_\_\_\_ Agency code \_\_\_\_\_

Name of agent \_\_\_\_\_

### 12. Will this insurance replace or cause change in any existing insurance?

Yes  No (If "Yes" please complete and attach a comparison disclosure statement.)

### 13. Are you now hospitalized or confined to a clinic, a nursing home, a rest home, a hospital, a special care institution or at your residence?

Yes  No (If "Yes" do not submit this application.)

### 14. Have you been treated for any type of cancer during the past three years?

Yes  No (If "Yes" do not submit this application.)

### 15. Have you been informed that you have tested positive for the human immune deficiency virus (HIV) or have you been informed that you have acquired immune deficiency syndrome (AIDS) or any aids-related disease?

Yes  No (If "Yes" do not submit this application.)

I represent that the statements and answers in this application are true and complete to the best of my knowledge and belief. It is agreed that:  
a) No agent has the authority to make or alter any contract for the Company; b) Insurance shall take effect when all of the following are satisfied:  
1) A policy issued by the Company is accepted by the applicant; 2) the full first premium is paid.

I understand and agree to the restriction in death benefit in the first two policy years.

**Medical authorization:** For claim purposes, I hereby authorize any physician, hospital, clinic, insurance company, or other organization institution or government office (including the Ontario Health Insurance Plan or the Régie de l'assurance-maladie du Québec) that has medical information about me to provide Assumption Life with any such information. A photocopy of this authorization shall be as valid as the original.

Signed at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_ 20 \_\_\_\_\_

Agent

Signature of proposed insured

Agent or broker notice to applicant: I declare being paid by  
 commissions and/or  fees and share this remuneration

with: \_\_\_\_\_

Signature of owner or applicant (if other than proposed insured).

### RECEIPT

Received from \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_ 20 \_\_\_\_\_

a premium deposit of \$ \_\_\_\_\_ in connection with an application for life insurance.

Signature of Agent \_\_\_\_\_

NOTE: If you do not receive a policy or refund of the amount you paid within 60 days from the date of this receipt, please notify the Company.

