Assumption Life
Group Insurance

Give this copy to the employee

NOTICE

RECORDS AND PERSONAL INFORMATION

For the purpose of administering your group insurance plan, Assumption Life collects personal information about you and any other proposed insured. Assumption Life may retain the services of a specialized administrator to manage your insurance file as well as your claims.

In order to protect the confidentiality of your personal information, Assumption Life is responsible for ensuring that a file is established and retained according to the applicable rules, in the offices of Assumption Life or third parties acting on our behalf, in Canada or elsewhere, 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.). When reviewing your insurance application or assessing a claim, we, our service providers 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.

For underwriting purposes or 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 course of this investigation, family members, friends and neighbors may be questioned about you.

We may also, for medical underwriting purposes, seek the assistance of a physician or a paramedical organization or a clinic in order to have you undergo a medical examination, X-rays, an electrocardiogram or to collect a blood, urine or saliva sample. The analyses will be used to determine the existence of various abnormalities such as diabetes, hepatic, kidney, or liver disorder, bone disease, immune disorder, infections caused by the AIDS virus, and the presence of medication, drugs, nicotine or their metabolites and to determine cholesterol and any related blood lipid levels.

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, health care professional or service provider) who need the personal information for the performance of their duties will have access to your file. If necessary, your personal information may also be shared with your beneficiaries or personal representative in relation to a claim for a death benefit.

Your personal information may be securely used, stored or accessed in other countries and may be subject to the laws of those countries. We may have to disclose your personal information in response to a request from government authorities or a court order in these countries.

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
Moncton NB E1C 8L1
Telephone: 506-869-9797 or 1-888 869-9797 Fax: 506-853-5434.

NOTICE FROM MIB, Inc. (MIB)

Information regarding your insurability will be treated as confidential. Assumption Life or its reinsurers may, however, make a brief report thereon to MIB, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or accident and sickness insurance coverage, or a claim for benefits is submitted to such company, MIB, upon request, will supply such company with the information in its files. As a U.S.-based company, MIB is bound by, and such personal information may be disclosed in accordance with, applicable U.S. laws.

Upon receipt of a request from you, MIB will arrange disclosure to you of any information it may have in your file. Please contact MIB at 416-597-0590. If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedure set forth in the U.S. Federal Fair Credit Reporting Act. The address of MIB's information office is 330 University Avenue, Suite 501, Toronto, Ontario M5G 1R7. To learn more about MIB, visit www.mib.com.

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

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Assumption Life
Group Insurance

ERASE

Statement of Health

Employee's name _____ Date of birth (DD/MM/YYYY)_____ /_____/ _____

Policy_____ Division _____ Certificate _____ Occupation_____

Address _____

Gender ☐ M ☐ F Telephone – Home _____ Telephone – Work_____

If applying for **dependent coverage**, indicate: Dependent's name _____Date of birth (DD/MM/YYYY) ____ / ____ / _____

1. a. Your height_____ft/in OR_____m/cm b. Your weight_____lbs OR_____kg
   c. Name and address of your physician _____

	Yes / No
2. Has your weight changed by more than 9.08kg (20 lbs) in the last year? If yes, state the amount of gain_____lbs/_____kg or loss _____lbs/_____kg and the reason _____. If the reason is pregnancy, state the date/expected date of delivery. _____	☐ ☐
3. Have any of your close biological family members (father, mother, brother, sister), living or deceased, ever been diagnosed with any of the following: diabetes, cancer, stroke, cardiac disorder, multiple sclerosis (MS), motor neuron disease (such as ALS or Lou Gehrig's, muscular dystrophy), Alzheimer's, Parkinson's, Huntington's, or polycystic kidney disease or any other hereditary disease? **If yes, complete the following chart:**	☐ ☐

Relationship	Disease / Disorder (if cancer, state the location)	Age at onset of illness	Age if living	Age at death	Cause of death

4. Are you taking any medication? **If yes, complete the following chart:**					☐ ☐
Name of medication	**Reason**	**Dosage**	**Frequency**	**Date began**	

5. In the past 12 months, have you used any substance or product containing tobacco, nicotine, or marijuana mixed with nicotine or used e-cigarettes? **If yes, specify: Type** _____ **Quantity** _____ **Frequency** _____	☐ ☐
6. Are you aware of any symptoms for which you have not yet consulted a physician or specialist or received treatment, or for which you have consulted a physician without having received a diagnosis? **If yes, specify the symptoms and the date or expected date of the appointment:** _____	☐ ☐
7. In the past 10 years, have you used any drugs except as prescribed by a physician or received advice or treatment for alcohol or drug abuse? **If yes, complete question 11, on the following page.**	☐ ☐
8. In the past 10 years, have you consulted a physician or been treated for: high blood pressure, high cholesterol, asthma, cystic fibrosis or other respiratory disorder, diabetes, back, neck or spinal disorder, arthritis, depression, anxiety or any other nervous disorder, ulcer, colitis or Crohn's disease? **If yes, complete the pertinent question 12 to 19, on the following page.**	☐ ☐
9. In the past 10 years, have you been absent from work due to injury or illness for more than 30 consecutive days or have you applied for or received a disability benefit or compensation due to injury, illness or disability? **If yes, complete question 20, on the following page.**	☐ ☐
10. Have you ever been tested for, received treatment for, or had any known indication of any of the following conditions or symptoms: **If yes, circle the relevant impairment(s) and complete question 20, on the following page.**	☐ ☐
a. Chest pain, heart murmur, abnormal pulse, abnormal electrocardiogram (ECG), palpitations, stroke, transient ischemic attack (TIA), anemia, or any other heart, circulatory or blood disorder/disease?	☐ ☐
b. Disorder of the muscles, bones, or joints, amputation, fibromyalgia, chronic fatigue syndrome, paralysis or cerebral palsy?	☐ ☐
c. Convulsion, epilepsy, chronic vertigo, fainting, headaches, multiple sclerosis (MS), motor neuron disease (such as ALS or Lou Gehrig's, muscular dystrophy), Alzheimer's or Parkinson's disease, dementia or any other neurological disorder?	☐ ☐
d. Disorder of the thyroid, bladder, kidney, liver (including hepatitis B or C), prostate, genital or reproductive organs, bowel, stomach, pancreas or gallbladder?	☐ ☐
e. Cancer, leukemia, lymphoma, melanoma, tumor, cyst, nodule, colon polyps, any breast disorder or abnormal breast discharge or change in appearance (other than surgery for cosmetic reasons), abnormal PAP test, or any other abnormal growth?	☐ ☐
f. AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS-Related Complex), AIDS virus antibody, or any other immunological disorder?	☐ ☐
g. Disorder of the eyes (excluding corrective lenses), ears, nose, throat, or mouth or loss of speech?	☐ ☐
h. Do you suffer from any congenital or physical impairment, disorder or disease, or have you had any abnormal test results that have not been mentioned above?	☐ ☐

Declaration and Authorization

• I confirm that the information and answers that I have provided in this statement of health, including the answers provided to questions 11 to 20, if applicable, and in any related document are true and complete and acknowledge that they constitute the basis for my insurance coverage. • I understand that if any answer is false or incomplete, any insurance coverage granted may be voided. • I understand that I may be refused for insurance coverage if, in the opinion of Assumption Life, I am not insurable for the insurance coverage. • I understand that any changes in the accuracy 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 consent to the medical examinations, electrocardiograms, blood, urine and saliva tests as may be required to medically underwrite my application. I further consent to Assumption Life releasing the results of these tests to its reinsurers, if required, to my attending physician and to MIB, Inc. (MIB) • I acknowledge receipt of Assumption Life's **Notice for records and personal information and from MIB** • I authorize Assumption Life, or its reinsurers, to make a brief report of my personal health information to MIB • I authorize any physician, healthcare professional, hospital, clinic, or other medical or paramedical establishment, as well as any insurance company, administrator of the group insurance plan, administrator of a government program or any other benefits program or agency, MIB, institution or person that holds records or information pertaining to me or my health status, or pertaining to my children and their health status (when an insurance application on the life of a child is requested), to gather and exchange such records or information with Assumption Life or its reinsurers for underwriting and claims adjudication purposes. • 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 have retained a copy of this Statement of Health. • I acknowledge that a copy of this authorization shall be as valid as the original.

_____ _____

Signature of the proposed insured (parent or legal guardian if dependent is a minor) **Date** (DD/MM/YYYY)

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Proposed Insured's name: _____

11. ALCOHOL AND DRUG CONSUMPTION

a. Name the drugs that you have consumed _____
b. Quantity _____ Frequency _____ Date last consumed _____
c. Have you consulted a physician or received treatment due to your drug consumption? ☐ Yes ☐ No
If yes, state the date of the consultation or treatment _____
d. Have you consulted a physician or received treatment due to your alcohol consumption? ☐ Yes ☐ No
If yes, state the date of the consultation or treatment _____
e. Date of your last: Alcohol consumption _____ Drug consumption _____

12. HYPERTENSION

a. Date of onset _____ Cause (if known) _____
b. Your blood pressure is: ☐ Controlled ☐ Not controlled Date and result of your last blood pressure reading _____

13. HIGH CHOLESTEROL

a. Date of onset _____
b. Your cholesterol is: ☐ Controlled ☐ Not controlled

14. ASTHMA OR RESPIRATORY DISORDER

a. Type ☐ asthma ☐ acute bronchitis ☐ chronic bronchitis ☐ emphysema ☐ other (specify) _____
b. Frequency of episodes _____ Date of last episode _____
c. Hospitalization? ☐ Yes ☐ No Dates _____ Time off work? ☐ Yes ☐ No Dates _____
d. Type of treatment _____ Emergency visits? ☐ Yes ☐ No Dates _____

15. DIABETES

a. Date of onset _____ b. Type of treatment ☐ insulin ☐ oral medication ☐ diabetic diet _____
c. Date and result of your last glucose level _____ and HbA1c _____
d. Have you had any complications related to your diabetes (eye, kidney, circulation, neurological)? ☐ Yes ☐ No
Specify _____

16. BACK, NECK OR SPINAL DISORDER

a. What area of your back was involved? ☐ neck ☐ middle (thoracic) ☐ lower (lumbosacral) ☐ other (specify) _____
b. What was the cause? _____ Diagnosis (if known) _____
c. Date of first episode _____ Date of last episode _____
d. Hospitalization required? ☐ Yes ☐ No Dates _____ Complications? ☐ Yes ☐ No Specify _____
e. Type of treatment _____ Date of last treatment _____
f. Have you had any X-rays or other tests on your back? ☐ Yes ☐ No If yes, date and results _____
g. Did you consult with a specialist? ☐ Yes ☐ No If yes, specify date and name of specialist _____
h. Do you have any restrictions in your activities or limitations of movement? ☐ Yes ☐ No
Specify _____

17. ARTHRITIS

a. Type ☐ rheumatoid ☐ osteoarthritis ☐ other (specify) _____
b. Date of onset _____ Frequency of episodes _____ Date of last episode _____
c. Time off work? ☐ Yes ☐ No Dates _____
d. Type of treatment _____ Date of last treatment _____
e. Did you consult with a specialist? ☐ Yes ☐ No If yes, specify date and name of specialist _____
f. Do you have any restrictions in your activities or limitations of movement? ☐ Yes ☐ No Specify _____

18. DEPRESSION, ANXIETY OR OTHER NERVOUS DISORDER

a. Type of symptoms ☐ insomnia ☐ anxiety ☐ nervousness ☐ fatigue ☐ suicidal thoughts ☐ suicide attempt ☐ phobia ☐ depression ☐ other (specify) _____
b. Date of onset _____ Cause _____
c. Frequency of episodes _____ Date of last episode _____
d. Hospitalization? ☐ Yes ☐ No Dates _____ Time off work? ☐ Yes ☐ No Dates _____
e. Type of treatment _____ Date of last treatment _____
f. Did you consult with a psychiatrist? ☐ Yes ☐ No
If yes, specify date and name of psychiatrist _____

19. ULCER, COLITIS OR CROHN'S DISEASE

a. Type ☐ ulcer ☐ colitis ☐ ulcerative colitis ☐ Crohn's disease ☐ other (specify) _____
b. Frequency of episodes _____ Date of last episode _____
c. Hospitalization? ☐ Yes ☐ No Dates _____ Complications? ☐ Yes ☐ No Dates _____
d. Type of treatment _____ Date of last treatment _____

20. IF YOU HAVE ANSWERED YES TO ANY OF THE QUESTIONS IN NUMBER 9 OR 10, ON THE PREVIOUS PAGE, PROVIDE DETAILS BELOW.

QUESTION NO.	CONDITION, DISORDER, DIAGNOSIS	DATE BEGAN	DATE ENDED	TREATMENT
	RESULTS _____			
	RESULTS _____			
	RESULTS _____			
	RESULTS _____			
	RESULTS _____			

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