myDIGNITY

HomeCare Expenses

Assumption Life

Assumption Mutual Life Insurance Company, doing business under the name Assumption Life
P.O. Box 160 / 770 Main St., Moncton NB E1C 8L1 | Tel. 1 888 869-9797 Fax 506 853-5434 E-mail: group@assumption.ca

myDIGNITY HomeCare Expenses

NOTICE

RECORDS AND PERSONAL INFORMATION

For the purpose of administering your insurance plan, Assumption Life collects personal information about you. 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 neighbours may be questioned about you.

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.

Statements and claim cheques, which may contain personal information pertaining to the insured persons, will automatically be sent to you the insured.

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.

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.

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

Give this copy to the insured person

Assumption Life

Assumption Mutual Life Insurance Company, doing business under the name Assumption Life
P.O. Box 160 / 770 Main St., Moncton NB E1C 8L1 | Tel. 1 888 869-9797 Fax 506 853-5434 E-mail: group@assumption.ca

myDIGNITY

HomeCare Expenses

APPLICATION

☐ New enrolment

Application number:

For agent use	Agent information	Code	%
MGA (if applicable) Milestone Insurance	Name of servicing agent Benefits By Choice Inc	611051091	50
	Name of agent (2)		

1. INSURED INFORMATION

First Name: Last Name:

Date of Birth: _____/_____/_____ (DD / MM / YYYY) | Gender: ☐ M ☐ F | Language Preference: ☐ English ☐ French

Address: _____
P.O. Box No. & Street Apt. No. City Province Postal Code

Telephone: _____ - _____ - _____ Home | _____ - _____ - _____ Office | _____ - _____ - _____ Cell

E-mail: | Carp Member Number:

2. OWNER (IF DIFFERENT FROM THE INSURED)

First Name: Last Name:

Date of Birth: _____/_____/_____ (DD / MM / YYYY) | Gender: ☐ M ☐ F | Language Preference: ☐ English ☐ French

Address: _____
P.O. Box No. & Street Apt. No. City Province Postal Code

Telephone: _____ - _____ - _____ Home | _____ - _____ - _____ Office | _____ - _____ - _____ Cell

E-mail:

Assumption Life

Assumption Mutual Life Insurance Company, doing business under the name Assumption Life
P.O. Box 160 / 770 Main St., Moncton NB E1C 8L1 | Tel. 1 888 869-9797 Fax 506 853-5434 E-mail: group@assumption.ca

myDIGNITY

HomeCare Expenses

3. CHOICE OF COVERAGE

		Annual Premium $
HomeCare Expenses **Home Care Services, Supplies and Equipment**	☐ Plan 1 — $50 000	
	☐ Plan 2 — $100 000	
	Policy fee	
	Total annual premium	
	Monthly premium = Annual premium x 0.09	

If more than one member of the same family subscribes to HomeCare Expenses at the same time.
A discount of 10% is applicable for the insured, the spouse and the following additional insureds:

Name	**Application Number**	Relationship
Name	**Application Number**	Relationship

4. BANKING INFORMATION

(Please attach a blank cheque marked "VOID" or provide the following banking information if no cheque is available.)

Name of Financial Institution:

Address of Financial Institution:

Insert the numbers found on the bottom of the cheque, as shown in the following example:

Branch Number:	Financial Institution Number (Bank):	Account Number:
☐☐☐☐☐	☐☐☐	☐☐☐☐☐☐☐

5. PREMIUMS AND METHOD OF PAYMENT

☐ **Monthly Pre-authorized debit $** _____ (See section 6)

Desired withdrawal date: the _____ day of each month (except 29th,30th, and 31st)

☐ **Annual Pre-authorized debit $** _____ (See section 6)
The initial withdrawal date will be the same as the date of issue of the policy. Afterwards, the withdrawal date will be the same as the renewal date.

☐ **Annual $** _____

Amount paid with application **$** _____

Make cheque payable to Odyssee Insurance in Trust.
Odyssee Insurance is the third party administrator on behalf of Assumption Life.

Assumption Life

Assumption Mutual Life Insurance Company, doing business under the name Assumption Life
P.O. Box 160 / 770 Main St., Moncton NB E1C 8L1 | Tel. 1 888 869-9797 Fax 506 853-5434 E-mail: group@assumption.ca

my DIGNITY

HomeCare Expenses

6. PRE-AUTHORISED DEBIT (PAD) AGREEMENT

Only fill out for a NEW insurance POLICY, 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 (check the appropriate box)	☐ **PERSONAL** — If debit is from a personal account ☐ **BUSINESS** — If debit is from a corporate account
Withdrawal Arrangements This pre-authorised agreement is considered a variable one.	1. 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. 2. If a pre-authorised 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 pre-authorised payment.** 3. I agree to the debiting of my account on the regular pre-authorised debit (PAD) withdrawal day as indicated on the application or the next business day (Subject to change). 4. If all preconditions for the **conditional temporary 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. ☐
Waiver	**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 pre-authorised 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 pre-authorised 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 pre-authorised bank account for the premium payment are for the exclusive benefit of the owner of the insurance policy.

*Assumption Life will not increase your pre-authorised debit or change your debit date after your insurance contract becomes effective without notifying you.

myDIGNITY

HomeCare Expenses

7. NAME, SIGNATURE AND TITLE OF PAYERS (ACCOUNT OWNERS) FOR «PAD»

Only fill out if different from the proposed insureds or owners named in sections 6 and 7

If two signatures are required to sign on the account, both account owners must sign this Authorization.

If the **Account Owner** is a **Body Corporate** (corporation, association, etc.), the signature of the authorized individuals with their **title is required.**

PRE-AUTHORISED DEBIT AGREEMENT: In the event that this declaration is for the addition of a policy rider or of a policy instead of a rider on an existing policy simply because the agent is not the service agent on the existing policy, you hereby acknowledge and agree that the banking information on file for the existing policy will be used for the rider or policy referred to in this declaration, including the withdrawal date. In the case of a policy instead of a rider on an existing policy simply because the agent is not the service agent on the existing policy, you also agree to the withdrawal of the first premium from the date of issue of the policy to which this declaration applies. Subsequent premiums will be withdrawn on the same date as the existing policy's premiums.

Name: _____

Title: _____

Signature: X _____

Name: _____

Title: _____

Signature: X _____

8. HEALTH DECLARATION

The insured declares that in the past five (5) years, he/she:

1) Was not hospitalized for depression or anorexia.
2) Has not required a treatment program consisting of three or more medications for any mental or nervous disorder.
3) Has not attempted to commit suicide.

The insured also declares that he/she has never had any of the following:

1) AIDS (acquired immune deficiency syndrome), AIDS–related complex (or tested positive on the AIDS virus antibody test).
2) Cirrhosis of the liver, active hepatitis B, or hepatitis C.
3) Bladder or bowel incontinence requiring regular use of incontinence supplies.
4) Amputation due to a disease.
5) Insulin-dependent diabetes (except gestational diabetes, but you are no longer pregnant and diabetes has been ruled out).
6) Cystic fibrosis or pulmonary fibrosis.
7) Two or more TIAs (mini-strokes), a stroke, paralysis, multiple sclerosis (MS), motor neuron disease (such as ALS or Lou Gehrig's, muscular dystrophy), memory loss, senility, dementia, Alzheimer's, Parkinson's, Huntington's or polycystic kidney disease.
8) Sickle-cell anemia, two or more cancers (other than basal cell carcinoma) or organ transplant.
9) Osteoporosis with fractures or systemic lupus erythematosus (SLE).

The insured also declares that he/she currently does not have an alcohol or a drug dependency or has not had one in the past 3 years.

The insured also declares that he/she is not currently:

1) Using a cane, a walker or a wheelchair.
2) Undergoing renal dialysis.
3) Being treated with oxygen for any condition.
4) Suffering from dizziness for which a diagnosis has not yet been made.
5) Receiving any type of disability benefits or has not received any type of disability benefits in the past for which a claim lasted longer than one year.

Signed at _____ (Province), this day of _____, 20_____.

Signature : _____
Signature of the Insured

Signature : _____
Signature of the agent or witness

myDIGNITY

HomeCare Expenses

9. DECLARATION OF PROPOSED INSURED AND OWNER

» I have requested that the application be in English, and I request that all other related documents be in English also.

» I acknowledge that any misrepresentation or failure to inform Assumption Life of all material facts in connection with the insurance may render the policy voidable at our option within two years from the later of the date of issue of the policy or the last date of reinstatement. Fraud will automatically render the policy void and the responsibility of the insurer will be limited to the reimbursement of the premiums of the last 12 months minus the claims paid. No benefit will be payable in either case and I must reimburse any benefits received.

» I understand that a telephone interview or other means may occasionally be used to complete the declaration of insurability, that such interview could be recorded, and that Assumption Life's acceptance of this application will also be based on those declarations.

» I understand that no insurance agent or person other than Assumption Life is authorized to modify, cancel or waive a question or provision of the 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 the application.

» I understand that the policy takes effect on the date the application is approved by Assumption Life provided that:

1) It has been approved without amendment;
2) The first policy premium has been paid; and
3) Any information or answer provided in the application remains complete and true on the date the application is approved by Assumption Life or on the date of issue of the policy, if later.

If the policy is approved with amendments, it will take effect on the date it is delivered to Assumption Life, provided that any insured person's health status remains unchanged.

» PREMIUM PAYMENT: I acknowledge that any amount paid with the insurance application bearing the same number as this addition 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.

10. DECLARATIONS, AUTHORIZATIONS AND SIGNATURE

On the date of signing of this application, the insured declares the following:

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

» I understand that if any answer is false or incomplete, any insurance coverage granted may be voided.

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

I acknowledge receipt of Assumption Life's Notice for records and personal information.

This authorization is valid for the purposes of this contract.

Signed at _____ (Province), this day of _____, 20____.

Signature : _____
Signature of the Insured

Signature : _____
Signature of the agent

Assumption Life

Assumption Mutual Life Insurance Company, doing business under the name Assumption Life
P.O. Box 160 / 770 Main St., Moncton NB E1C 8L1 | Tel. 1 888 869-9797 Fax 506 853-5434 E-mail: group@assumption.ca