Assumption Life
Group Insurance

NOTICE

RECORDS AND PERSONAL INFORMATION

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

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 in which the information pertaining to your application for insurance, as well as the information pertaining to any insurance claim, will be placed established and retained according to the applicable rules. 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 when reviewing your insurance application or assessing a claim.

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 NB E1C 8L1.
Tel: 1-888-869-9797 Fax: 1-855-401-9068

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 1-855-801-9068E-mail: group@assumption.ca

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Application for Group Insurance

Section 1 To be Completed by Group Administrator

Employer _____ Policy _____ Division _____ Employee category _____

Occupation _____ ☐ Permanent ☐ Seasonal (if seasonal, please indicate the number of months at work _____)

Hiring Date (DD/MM/YYYY) ___/___/_____ Effective Date (DD/MM/YYYY) ___/___/_____ Salary $_____ ☐ hourly ☐ weekly ☐ monthly ☐ yearly

Hours/week worked _____ **(# of hours per week is mandatory)**

Section 2 To be Completed by the Employee

First Name _____ Last Name _____ Date of Birth ___/___/_____ (DD / MM / YYYY) Gender ☐ M ☐ F Language Preference ☐ French ☐ English

Address _____ City _____ Province _____ Postal Code _____

Telephone: (_____)_____-_____ Home (_____)_____-_____ Office (_____)_____-_____ Cell

E-mail _____

Section 3 Choice of plan (if applicable to your policy)

Please choose between: ☐ Single ☐ Family ☐ Couple* ☐ Single-Parent*

***If not provided under your contract, this will be considered as family coverage**

Section 4 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. Please note that the information of the dependents must be indicated below.

	First Name	Last Name	Gender	Date of Birth Day	Month	Year	Dependent Status	
Spouse:*			☐ M ☐ F				☐ (1)	☐ Married
Children:			☐ M ☐ F				☐ (2)	☐ Student (3)
Children:			☐ M ☐ F				☐ (2)	☐ Student (3)
Children:			☐ M ☐ F				☐ (2)	☐ Student (3)
Children:			☐ M ☐ F				☐ (2)	☐ Student (3)
Children:			☐ M ☐ F				☐ (2)	☐ Student (3)

(1) ☐ If common-law spouse, please specify the date cohabitation began (DD/MM/YYYY) ___/___/_____

(2) Total Disability– if the dependent has a physical or mental handicap

(3) Student – if the dependent is overaged and a full-time student in a recognized academic institution

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Section 5 Coordination of Benefits (If you do not have a spouse or choose to complete section 6, this section does not apply)

Does your spouse have health coverage under his/her own insurance plan? Yes ☐ No ☐

If yes, is the health coverage an/a: ☐ Individual plan ☐ Family plan

Does your spouse have dental coverage under his/her own insurance plan? Yes ☐ No ☐

If yes, is the dental coverage an/a: ☐ Individual plan ☐ Family plan

Name of spouse's insurer: _____ Contract Number: _____

Section 6 Waiver of Benefits

Comment : All benefits under your group insurance plan are mandatory. However, you may waive the health and dental 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:

	Myself and my dependents	My dependents
Health Insurance	☐	☐
Dental Insurance	☐	☐

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 request, if need be, the dental insurance will be limited.

Name of spouse's insurer: _____ Contract Number: _____

Section 7 Request for Optional Life Insurance (if provided under your plan)

☐ Optional Life Insurance $ _____ ☐ Optional Life Insurance for Spouse $ _____

Please provide a statement of health form.

Section 8 Beneficiary Designation

PRIMARY BENEFICIARY First Name Last Name	Date of Birth (DD/MM/YYYY)	%	Revocable	Irrevocable	Relationship to employee
			☐	☐	
			☐	☐	
			☐	☐	
Total (must be equal to 100%)					
CONTINGENT BENEFICIARY First Name Last Name	Date of Birth (DD/MM/YYYY)	%	Revocable	Irrevocable	Relationship to employee
			☐	☐	
			☐	☐	
			☐	☐	
Total (must be equal to 100%)					

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

Relationship of trustee to the employee: _____

Unless otherwise stipulated or not permitted by law, any beneficiary designation is revocable. If a beneficiary is named irrevocably, please note that his/her consent is required for any request that may affect his/her rights, including a change of beneficiary. In Quebec, the designation of the owner's married or civil union spouse as beneficiary is irrevocable, unless otherwise stipulated. The policy does not confer any rights to contingent beneficiaries prior to the death of the primary beneficiaries.

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Section 9 Declarations, Authorizations and Signature

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 enroll in this group insurance plan in their name. (Only applicable if you have requested coverage for your spouse and/or children).

I authorize my employer to collect personal information about me and my dependents, if applicable, provided in this enrolment form and withdraw the necessary contributions from my salary and remit them to Assumption Life.

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 collect and 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 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 (DD/MM/YYYY)

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