LIA WORKSHEET
FOR UNDERWRITTEN PRODUCTS
COMPLETE FOR EACH INSURED
#_____

Assumption Life

DELETE

PRODUCT SELECTION

PERMANENT INSURANCE

NON-PARTICIPATING WHOLE LIFE

☐ Life pay (payable to attained age 100)

☐ 20-pay

Policy Option

☐ Individual ☐ Joint first-to-die ☐ Joint last-to-die

Sum Insured $_____ (Min. $10,000 for ages 18 to 75 and $5,000 for ages 76 to 80 - Max. $10,000,000)

PARPLUS (PARTICIPATING)

☐ Life pay (payable to attained age 100)

☐ 20-pay

Policy Option

☐ Individual ☐ Joint first-to-die

Sum Insured (Min. $5,000 – Max. $4,000,000) $_____

Dividend Option

☐ Cash ☐ Premium reduction ☐ Accumulation ☐ Paid up additions
☐ Enhanced 15 - year guarantee
☐ Enhanced - guaranteed until attained age 100

TERM INSURANCE

FLEXTERM (LEVEL OR DECREASING TERM)

☐ Level ☐ Decreasing

☐ 10 yrs ☐ 15 yrs ☐ 20 yrs ☐ 25 yrs ☐ 30 yrs ☐ 35 yrs

Policy Option

☐ Individual ☐ Joint first-to-die

Sum Insured (Min. $100,000 – Max. $10,000,000) $_____

GENERAL INFORMATION

First Name:	Last Name:	Previous Last Name:
Occupation	Name of Employer:	Annual (Employment) Income:

Province of Birth:

Country of Birth:

Date of Birth: _____
YYYY / MM / DD

Age: _____ (at nearest birthday)

Gender:
☐ M
☐ F

Present residency status in Canada:

☐ Canadian citizen
☐ Permanent resident (landed immigrant)
☐ Other (specify)_____

If other, indicate date arrived in Canada: _____
YYYY / MM / DD

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

Telephone #: Home _____ Work _____

Email: _____

In the past 12 months, have you used any tobacco or nicotine products, including, but not limited to cigarettes, large cigars (more than 12), cigarillos, marijuana or cannabis mixed with tobacco, e-cigarettes, vaping devices, gum, patches, chewing tobacco, snuff, betel nuts, shisha, or hookah/water pipes?

☐ No ☐ Yes

This is not an application. Do not submit.
The information in this document is only valid once uploaded into Assumption Life's electronic sales platform, Lia.

ADDITIONAL BENEFIT RIDERS

☐ DI based on loans (Loan repayment option) $_____ per month (min. $300, max. $3,500 ($1,500 if on parental leave) not exceeding 1.5% of the sum insured)

☐ DI based on employment income (Income replacement option) $_____ per month (min. $300, max. $3,500 ($1,500 if on parental leave) not exceeding 1.5% of the sum insured or 75% of the annual employment income divided by 12)

☐ Accidental Death (AD)*: $_____

☐ Child Insurance Benefit: ☐ $10,000 ☐ $20,000

☐ Waiver of premium upon disability (WP)**

☐ Waiver of premium upon death (WPD)**

☐ Accidental Fracture Plus: ☐ Insured ☐ Insured and Spouse ☐ Insured and Child ☐ Insured, Child and Spouse ☐ 1 unit ☐ 2 units	Name of the Insured's spouse:	
	Complete name of the Insured's children:	
	1.	4.
	2.	5.
	3.	6.

**AD Rider amount cannot be greater than the initial sum insured. AD is not available on joint policy.*
***If WP/WPD is for owner or payer, please use a separate form.*

COMBINATION OF LIFE INSURANCE AND CRITICAL ILLNESS INSURANCE

When life insurance and critical illness insurance are requested as part of the same insurance application for the same proposed insured, the critical illness insurance data collection form must also be completed. The Critical Illness Insurance data collection form is available on our Advisor's Corner website.

REPLACEMENT

Is the insurance requested intended to replace an existing individual life insurance? ☐ No ☐ Yes*

**If Yes, please ensure that you satisfy the Proposed Insured's province's disclosure requirements pertaining to the replacement of a life insurance policy. Moreover, if the original policy being replaced is with Assumption Life, a written notice or a ''policy service request'' signed by the owner of the original policy must be sent to Assumption Life in order to terminate the existing policy.*

FAMILY DOCTOR

Does the Proposed Insured have a family doctor? ☐ No ☐ Yes

If "Yes", please provide the following information:

Family Doctor Name: _____

Family Doctor Address: _____

☐ Family Doctor information not available at this time, to be provided at a later date

PAYMENT METHOD (Complete only on worksheet for Proposed Insured 1)

☐ Monthly (PAD) ☐ Annual (PAD) ☐ Annual ☐ Semi-Annual ☐ Quarterly	**Regular preauthorized debit (PAD) withdrawal day:** ☐ Coincides with day of application approval by Assumption Life ☐ On the_____(1st to 28th) day of the month

Has the payer been advised that by choosing a specific PAD date, it could result in two premium withdrawals within the first 30 days following the policy being put in force? ☐ No ☐ Yes

BENEFICIARY DESIGNATION

Beneficiary 1	☐ Estate ☐ Owner ☐ Other (if selected, please provide details below)			
	First name	Last name	Relationship to the Insured (Owner in Quebec)	
	Phone number	Date of birth: _____ YYYY / MM / DD	%*	☐ Revocable ☐ Irrevocable
Substitute Beneficiary	First name	Last name	Relationship to the Insured (Owner in Quebec)	
	Phone number	Date of birth: _____ YYYY / MM / DD	%*	☐ Revocable ☐ Irrevocable
Beneficiary 2	First name	Last name	Relationship to the Insured (Owner in Quebec)	
	Phone number	Date of birth: _____ YYYY / MM / DD	%*	☐ Revocable ☐ Irrevocable
Substitute Beneficiary	First name	Last name	Relationship to the Insured (Owner in Quebec)	
	Phone number	Date of birth: _____ YYYY / MM / DD	%*	☐ Revocable ☐ Irrevocable
Contingent Beneficiary (Upon death of all primary and substitute beneficiaries)	First name	Last name	Relationship to the Insured (Owner in Quebec)	
	Phone number	Date of birth: _____ YYYY / MM / DD	%*	☐ Revocable ☐ Irrevocable
	First name	Last name	Relationship to the Insured (Owner in Quebec)	
	Phone number	Date of birth: _____ YYYY / MM / DD	%*	☐ Revocable ☐ Irrevocable
Assign a Trustee**	First name	Last name	Relationship of the Trustee to the Beneficiary:	

*If a % is not stated, insurance proceeds will be payable in equal shares to the beneficiaries who survive the Proposed Insured. If a % is stated and a substitute beneficiary has been designated, insurance proceeds will be payable to the substitute beneficiary in the event that the primary beneficiary dies before the Proposed Insured. If no primary or substitute beneficiary survives the Proposed Insured, the insurance proceeds will be divided equally among all designated contingent beneficiaries who survive the Proposed Insured.

**A trustee should be named for any minor beneficiary. The designation of a trustee is not applicable in Quebec.

OWNER/PAYER INFORMATION (Complete only on worksheet for Proposed Insured 1)

Owner:	☐ Proposed Insured 1	☐ Proposed Insured 2	☐ Other or Body Corporate (complete below)		
Co-owner:	☐ Proposed Insured 1	☐ Proposed Insured 2	☐ Other (complete below)		
Payer:	☐ Proposed Insured 1	☐ Proposed Insured 2	☐ Owner	☐ Co-owner	☐ Other (complete below)

Indicate occupation

Social Insurance Number |___|___|___|___|___|___|___|___|___|

☐ Birth Certificate ☐ Driver's License ☐ Passport ☐ Other (Specify) _____

Reference Number _____ Place of Issue (Province/Country) _____

Banking Information (If possible, please include a personal cheque marked "VOID")

Bank Name:

Bank Number: | Branch number: | ☐ Savings ☐ Chequing

Account Number:

COMPLETE IF OWNER IS OTHER / PAYER (IF DIFFERENT)

Check box if applicable and complete only first name and last name. ☐ See data form for WP on Owner named afterward.

First Name:

Last Name:

Date of Birth: _____
YYYY / MM / DD

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

Telephone: Home _____ Work _____

Email: _____

Copy address: Proposed Insured ☐ 1 ☐ 2

Relationship with Proposed Insured

COMPLETE IF OWNER IS A BODY CORPORATE (CORPORATION, PARTNERSHIP, ETC.)

Name of Body Corporate:

Names of Directors

Name	Name
Name	Name

Names of persons authorized to sign for the Body Corporate with their title

Name	Title
Name	Title

Registration Number:

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

Telephone #: _____

TRANSACTION ON BEHALF OF A THIRD PARTY (ONLY NEEDED FOR PARPLUS AND NON-PARTICIPATING WHOLE LIFE)			
Have the owner(s) received money or instructions from anyone to purchase this life insurance? ☐ Yes ☐ No If yes, will the owner(s) have to give a portion of the cash surrender value upon policy's termination? ☐ Yes ☐ No			
Verification of owner and co-owner by means of an original document			
Owner (indicated above)		**Owner** (indicated above)	
SIN:		**SIN:**	
Type of Identity:		Type of Identity:	
Reference Number:		Reference Number:	
Place of Issue - Province:	Country:	Place of Issue - Province:	Country:

NOTES

DECLARATION OF INSURABILITY

PART A - MEDICAL ASSESSMENT

1. What is your height and weight?
Height _____ **Weight** _____

Height		Weight		Height		Weight		Height		Weight	
ft/in	cm	lb	kg	ft/in	cm	lb	kg	ft/in	cm	lb	kg
4’ 10’’	147	158	72	5’ 6’’	168	205	93	6’ 2’’	188	256	116
4’ 11’’	150	163	74	5’ 7’’	170	210	95	6’ 3’’	191	264	120
5’ 0’’	152	169	77	5’ 8’’	173	216	98	6’ 4’’	193	271	123
5’ 1’’	155	174	79	5’ 9’’	175	224	102	6’ 5’’	196	277	126
5’ 2’’	157	182	83	5’ 10’’	178	229	104	6’ 6’’	198	285	129
5’ 3’’	160	188	85	5’ 11’’	180	235	107	6’ 7’’	201	293	133
5’ 4’’	163	193	88	6’ 0’’	183	242	110	6’ 8’’	203	299	136
5’ 5’’	165	198	90	6’ 1’’	185	250	114	6’ 9’’	206	308	140

		NO	YES
2.	In the past 12 months, has your weight changed by more than 9.08 kg (20 lbs) other than due to pregnancy?	☐	☐
3.	Are you aware of any signs, symptoms, or abnormal medical tests for which: (You don’t need to tell us about common cold or flu symptoms, routine follow-up where there are no new symptoms, or routine prenatal visit.)		
	a) You have not yet consulted a physician, or you have consulted a physician without having received a diagnosis?	☐	☐
	b) You are currently being investigated?	☐	☐
	c) You have a pending consultation with a medical specialist? (A pending consultation does not include a routine follow-up, and a medical specialist does not include a general practitioner.)	☐	☐
	d) You have consulted a medical specialist without having received a diagnosis?	☐	☐
	e) You are currently waiting for surgery?	☐	☐
4.	Have you ever been advised by a physician that you have a terminal illness for which you are currently receiving Palliative or Hospice care or have discussed this type of care with a health professional?	☐	☐
5.	Have you ever been diagnosed with:		
	Immune System and Infectious Disorders a) AIDS (acquired immune deficiency syndrome) or tested positive for HIV (the virus that causes AIDS)?	☐	☐
	b) Systemic lupus erythematosus (SLE) or any other immunological disorder (such as scleroderma, morphea, or CREST syndrome)?	☐	☐
	c) Infectious disorders (such as Lyme disease, sexually transmitted infections, or unexplained infections)? You don’t need to tell us about uncomplicated and fully recovered COVID-19.	☐	☐
	Nervous System d) Huntington’s disease, amyotrophic lateral sclerosis (Lou Gehrig’s disease), Alzheimer’s disease, or dementia?	☐	☐
	Cardiovascular System e) Cardiomyopathy or congestive heart failure?	☐	☐
	Gastro-Intestinal System f) Cirrhosis of the liver, chronic pancreatitis, or two or more episodes of acute pancreatitis?	☐	☐
	Respiratory System g) Cystic fibrosis?	☐	☐

DECLARATION OF INSURABILITY (continued)		NO	YES
6.	In the past 10 years, have you been diagnosed with, hospitalized for, received treatments (including treatment with any prescribed medication) for, or had any known indication of:		
	Nervous System a) Convulsions, seizures, epilepsy, recurrent or severe headaches, multiple sclerosis, Parkinson's disease, tremors, memory loss, paralysis, numbness, or weakness?	☐	☐
	b) Disorder or injury of the brain, developmental delay, or other neurological disorder (such as autism spectrum disorder or Down's syndrome)?	☐	☐
	Cardiovascular System c) Cerebrovascular accident (stroke), transient ischemic attack (TIA or mini-stroke), heart murmur, high blood pressure, abnormal cholesterol levels, palpitations, arrhythmia (irregular heartbeat such as atrial fibrillation/flutter, tachycardia, bradycardia, supraventricular tachycardia, ventricular fibrillation, ectopic beats), chest pains, angina, heart attack (myocardial infarction), heart disease or any other disorder of the heart?	☐	☐
	Gastro-Intestinal System d) Disorder of the stomach (such as gastroesophageal reflux disease (GERD) or ulcer), liver, pancreas, gallbladder, or intestines (such as colon polyps, Crohn's disease, ulcerative colitis, or rectal bleeding), hepatitis B or C, or chronic diarrhea? You don't need to tell us about hemorrhoids or gallstones when the diagnosis has been confirmed by your doctor. If YES, complete and attach the Gastro-Intestinal Questionnaire (3894).	☐	☐
	Respiratory System e) Sleep apnea or respiratory or lung disorder (such as asthma, chronic obstructive pulmonary disorder (COPD), emphysema, or sarcoidosis)? If YES, complete and attach the Respiratory Disorder Questionnaire (3907).	☐	☐
	Musculoskeletal System f) Disorder or injury of the muscles, bones, back, neck, or joints (such as fibromyalgia, arthritis, osteoporosis, knee disorders, Carpal Tunnel Syndrome, or muscular dystrophy)? You need to tell us about rheumatoid arthritis if not already declared. If YES, complete and attach the Musculoskeletal Disorder Questionnaire (5449).	☐	☐
	Genitourinary System g) Disorder of the kidneys (such as stones, chronic kidney disease, polycystic kidney disease (PKD), or glomerulonephritis), ureter, bladder (such as stones, blood in urine, or abnormal urinalysis), prostate, or genital or reproductive organs? You don't need to tell us about uncomplicated urinary tract infection when the diagnosis has been confirmed by your doctor.	☐	☐
	Tumor and Cancer h) Leukemia, cancer, lymphoma, melanoma, tumor, cyst, lump, nodule, or any other abnormal cells or growth? If not previously declared in this application, you need to tell us about any abnormal breast lump or cyst, abnormal breast discharge or change in appearance, abnormal breast imaging, or abnormal PAP test.	☐	☐
	Endocrine System i) Diabetes, pre-diabetes, impaired glucose tolerance, or disorder of the glands, the endocrine system, or the lymph nodes? You don't need to tell us about controlled hypothyroidism.	☐	☐
	Mental Health j) Adjustment disorder, anxiety, depression, bipolar disorder, post-traumatic stress disorder, schizophrenia, eating disorder, attention deficit disorder, chronic fatigue, or suicidal thoughts or attempts, or any other psychological, emotional, or mental health disorder? If YES, complete and attach the Psychological or Nervous Disorder Questionnaire (3900).	☐	☐
	Circulatory System k) Disorder of the blood vessel (such as peripheral vascular disease or aneurysm) or blood (such as blood clot, anemia, or bleeding disorder)?	☐	☐
	Eyes, Ears, Nose, Throat, and Skin l) Disorder of the eyes (such as optic neuritis, blindness, or glaucoma and other than corrective lenses), ears (such as deafness or partial deafness), nose, mouth, throat, or skin? You don't need to tell us about acne or eczema.	☐	☐
Question 7 is for insured age 50 or under ONLY.			
7.	Do you have a biological family member (father, mother, brother, sister), living or deceased, who was diagnosed before age 60 with any of the following conditions: diabetes, cancer, stroke, heart disease, Huntington's disease, polycystic kidney disease (PKD), Alzheimer's, motor neuron disease, Parkinson's disease, or any hereditary disease?	☐	☐

DECLARATION OF INSURABILITY (continued)		NO	YES
Questions 8 and 9 are ONLY for insured aged: *18 to 45 for sum insured of $500,000 to $2,000,000.* *46 to 50 for sum insured of $250,000 to $999,999.* *51 to 55 for sum insured of $250,000 to $499,999.* *56 to 60 for sum insured of $250,000 to $300,000.*			
8.	Other than previously declared in this application, have you ever been diagnosed with:		
	a) Leukemia, cancer (other than basal cell carcinoma), lymphoma, melanoma, or tumor?	☐	☐
	b) Angina, heart attack (myocardial infarction), heart disease such as heart murmur, palpitations, arrhythmia (irregular heartbeat), or other heart disorder?	☐	☐
	c) Cerebrovascular accident (stroke) or transient ischemic attack (TIA or mini-stroke)?	☐	☐
	d) Glomerulonephritis or connective tissue disease?	☐	☐
9.	Other than previously declared in this application, in the past 2 years, have you had any other disease, disorder, or abnormal test results that have not yet been disclosed?	☐	☐
PART B - LIFESTYLE ASSESSMENT			
10.	In the past 2 years, have you used cannabis (such as marijuana or hashish) more than 3 times per week?	☐	☐
11.	In the past 10 years, have you used any other drugs or prescription medications that weren't prescribed to you such as cocaine, LSD, amphetamines, hallucinogens, narcotics, barbiturates, or anabolic steroids? You don't need to tell us about over-the-counter medications. If YES, complete and attach the Drug Use Questionnaire (3887).	☐	☐
12.	Have you ever been advised by a health professional to discontinue or reduce your consumption of alcohol or drugs, or have you received advice or treatment (including treatment with any prescribed medication) for alcohol or drug abuse? If YES, complete and attach the Drug and Alcohol Usage Questionnaire (6559).	☐	☐
13.	In the past 10 years, have you been incarcerated, on house arrest, on probation, or convicted of a crime or are you currently accused of a crime for which a verdict has not been rendered? If YES, complete and attach the Criminal Activity Questionnaire (5337).	☐	☐
14.	In the past 5 years, have you been accused or charged with an alcohol or drug-related driving offence or refused a breathalyzer? If YES, complete and attach the Driving Record Questionnaire (4018).	☐	☐
15.	In the past 2 years, have you received more than 3 tickets for moving violations, or had your license suspended or revoked? If YES, complete and attach the Driving Record Questionnaire (4018).	☐	☐
16.	In the past 2 years, have you engaged in any hazardous sports or activities or made flights other than as a fare-paying passenger or do you intend to engage in such sports, activities, or flights? If YES, complete and attach the Hazardous Sports/Activities Questionnaire (6816).	☐	☐
17.	Have you resided outside Canada in the past 12 months, or do you expect or plan to travel or reside outside North America, the Caribbean (excluding Haiti), or Western Europe in the next 12 months? If YES, complete and attach the Foreign Travel/Residency Questionnaire (3893).	☐	☐
PART C - OTHER INFORMATION			
18.	In the past 5 years, have you applied for life insurance, critical illness insurance, disability insurance or reinstatement that has been declined, postponed, or modified (with higher premiums or exclusion)? You don't need to tell us about health and dental insurance.	☐	☐
Question 19 is ONLY for insured aged: *18 to 60 for sum insured of $500,000 to $3,000,000.* *61 to 69 for sum insured of $250,000 to $3,000,000.* *70 to 80 for sum insured of $250,000 to $2,000,000.*			
19.	Is the total amount of life insurance applied for and in force more than 20 times your annual salary?	☐	☐

RIDERS (Questions below must be answered if one of the following additional benefit riders is chosen.)

WAIVER OF PREMIUM UPON DISABILITY

The waiver of premium upon disability is not renewable and terminates on the first of the following: on the expiry date of the policy's first term; on the rider anniversary nearest to the Insured's 60th birthday. The owner cannot be a Body Corporate (corporation, partnership, etc.).

☐ I have read the above statement and confirm that the Owner understands the terms and conditions.YES

Declaration of insurability		NO	YES
1.	In the **past three (3) years**, have you:		
	a. Been absent from work due to injury or illness for more than thirty (30) consecutive days?	☐	☐
	b. Applied for or received a disability benefit or compensation due to injury, illness or disability?	☐	☐
	c. Consulted or received any treatment from a physiotherapist, massage therapist, chiropractor or acupuncturist?	☐	☐

DI BASED ON LOAN OR DI BASED ON EMPLOYMENT INCOME

Determine eligibility - Proposed Insured must answer "**Yes**" the following three questions to be eligible.		NO	YES
1.	Are you currently working (or are you currently on a parental leave)?	☐	☐
2.	Are you working (or worked prior to your parental leave, if applicable) at least twenty (20) hours per week?	☐	☐
3.	Are you working (or worked prior to your parental leave, if applicable) at least eight (8) months per year?	☐	☐

Declaration of insurability		NO	YES
1.	In the **past three (3) years**, have you:		
	a. Been absent from work due to injury or illness for more than thirty (30) consecutive days?	☐	☐
	b. Applied for or received a disability benefit or compensation due to injury, illness or disability?	☐	☐
	c. Consulted or received any treatment from a physiotherapist, massage therapist, chiropractor or acupuncturist?	☐	☐

FOR ALL ''YES'' ANSWERS (for declaration of insurability section)

For all "Yes" answers, please give additional information:

Question Number	Explanation	Name of Physician	Hospital

CHILD INSURANCE BENEFIT (CIB)

Complete only if checked in the "ADDITIONAL BENEFIT RIDER" section.

List each natural or adopted child of Proposed Insured who is single and dependent upon this person for support

First and Last Name	Date of Birth (day/month/year)	Age	Sex	Height (ft/in or m/cm)	Weight (lb-oz or kg-g)
a.					
b.					
c.					
d.					
e.					

	Declaration of insurability	NO	YES
1.	Were any of the children to be insured born prematurely or with an abnormality or disease?	☐	☐
2.	Have any of the children to be insured been hospitalized or undergone any surgery?	☐	☐
3.	Are any of the children to be insured taking medication, following a special diet or undergoing treatment for any condition?	☐	☐
4.	Has any insurance on the children to be insured been refused, rated or issued with modifications?	☐	☐
5.	Is this insurance intended to replace any other life insurance on any of the children to be insured?	☐	☐
6.	Has any life insurance application been submitted to any other company within the past 12 months?	☐	☐

FOR ALL "YES" ANSWERS (for CHILD INSURANCE BENEFIT section)

For all "Yes" answers, please give additional information:

Name of Child	Question Number	Explanation	Name of Physician	Hospital

SPECIAL INSTRUCTIONS

☐ Date of issue coincides with the day the application is approved by Assumption Life except if approved on the 29th, 30th or 31st where the date of issue shall be on the 28th day of the month.

☐ Date of issue requested (YYYY/MM/DD): _____ /_____ /_____ (Example: 2026/01/13)

- No conditional temporary life insurance is applicable if the requested date of issue is in the future.
- Administrative restrictions may apply

IMPORTANT – MESSAGE TO REPRESENTATIVE

Please ensure that you have

- Provided and explained to the client an Advisor Disclosure Statement explaining your method of compensation and other financial benefits, the names of the insurance companies you represent as well as any conflict of interest.
- Duly verified the date of birth of all Proposed Insureds.
- Explained the questions contained on this form to all Proposed Insureds and Owners.

Name of representative (agent/broker) – Please print _____