

Disability Insurance Benefit Questionnaire

First Name : _____ Last Name : _____
 Policy Number : _____ Date of Birth : _____
 Occupation : _____

1. In the past twelve (12) months, has your employment been on a seasonal basis? Yes No
2. In the past twelve (12) months, have you been laid off? Yes No
3. In the past twelve (12) months, have you been working fewer than 20 hours per week? Yes No
4. In the past five (5) years, have you been absent from work due to an injury or sickness for more than five consecutive days? Yes No
5. Have you ever applied for or received a disability pension or compensation due to injury, sickness or disability? Yes No
6. Do you have a pending application for disability benefits with another company or do you intend to submit one? Yes No

If you have answered "Yes" to any of the preceding questions, please provide details below:

No. Details (date, duration, reason, current status, physician's name, company name)

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

7. In the event of disability, would you receive any benefits from another source? Yes No
 If yes, complete the following:

Company	Insurance Benefit	Amount per Month	Duration of Payment
_____	_____	_____	_____

8. State your gross income earned during the past three (3) years.

Year : _____	Income : _____
Year : _____	Income : _____
Year : _____	Income : _____

9. Are you receiving an income from any source other than your current employer? Yes No
 If yes, complete the following:

Employment	Rentals (net)	Interests and dividends	Annuities and other income	Total
_____	_____	_____	_____	_____

I declare that the above information is true and complete and acknowledge that it shall form part of my insurance application with Assumption Life.

 Signature of the person to be insured (parent or legal guardian if a minor) Date