

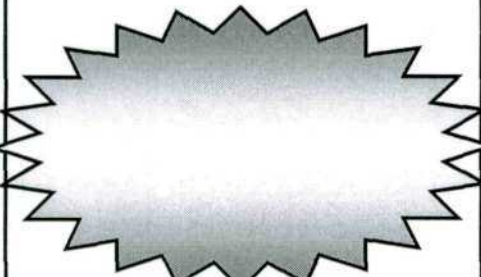
McGill/Assumption Life FlexOptions Application

BUSINESS	
NAME OF BUSINESS APPLICANT	PHSP#
<input type="checkbox"/> SELF-EMPLOYED <input type="checkbox"/> PROFESSIONAL PRACTICE <input type="checkbox"/> CORPORATION	
NATURE OF BUSINESS	

INDIVIDUAL TO BE COVERED			
<input type="checkbox"/> SAME AS ABOVE	NAME OF INSURED		
DATE OF BIRTH dd / mm / yyyy	SEX <input type="checkbox"/> M <input type="checkbox"/> F	SMOKER OR NON SMOKER	
NAME OF SPOUSE (IF JOINT COVERAGE)	SPOUSE'S DATE OF BIRTH dd / mm / yyyy	SMOKER OR NON SMOKER	

CONTACT INFORMATION			BENEFICIARY UPON DEATH OF INSURED		
ADDRESS			FIRST AND LAST NAME (PROPOSED INSURED 1) %		
			FIRST AND LAST NAME (PROPOSED INSURED 2) %		
City	Prov	Postal Code	RELATIONSHIP 1		RELATIONSHIP 2
PHONE	FAX		REV/IRREV	REV/IRREV	
E-MAIL			SIGNATURE OF PROPOSED INSURED - DATE		
PREFERRED COMMUNICATION: <input type="checkbox"/> PHONE <input type="checkbox"/> FAX <input type="checkbox"/> E-MAIL <input type="checkbox"/> MAIL					

PREMIUM QUOTED		Term Life + CI + DI OPTIONS	
SEMI-ANNUAL PREMIUM: \$	<input type="checkbox"/> AMOUNT APPLIED FOR:	<input type="checkbox"/> CRITICAL ILLNESS COVERAGE	
ANNUAL PREMIUM: \$	<input type="checkbox"/> SPOUSAL APPLIED FOR:	<input type="checkbox"/> INCOME REPLACEMENT COVERAGE	
(PAC) MONTHLY, VOID CHEQUE REQUIRED			

PAYMENT for:	
MORTGAGE INSURANCE SEMI OR ANNUAL ONLY 	<input type="checkbox"/> CREDIT CARD <input type="checkbox"/> VISA <input type="checkbox"/> MASTERCARD <input type="checkbox"/> AMEX
	EXPIRY DATE mm yy
SIGNATURE	
NAME OF CARDHOLDER (Please Print)	TODAY'S DATE dd mm yyyy
AGENT ID (Corp. Use Only)	

McGill/Assumption Life FlexOptions Medical Questionnaire - 02

Name of Individual to be covered:	PHSP NO.
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COVER	AMOUNT OF COVERAGE	SMOKER	PREMIUM	FREQUENCY
<input type="checkbox"/> SELF	<input type="checkbox"/> \$	<input type="checkbox"/> YES <input type="checkbox"/> NO	\$	<input type="checkbox"/> ANNUAL
<input type="checkbox"/> SPOUSE	<input type="checkbox"/> \$	<input type="checkbox"/> YES <input type="checkbox"/> NO	\$	<input type="checkbox"/> MONTHLY

MEDICAL QUESTIONNAIRE

		YES	NO
1. In the past two years, have you had any application for Life. Disability or Critical Illness insurance declined, postponed, cancelled, rescinded, rated or modified, for medical reason?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Within the past ten years have you had any: abnormal diagnostic test results, including mammograms, Pap tests or abnormal PSA test for prostate cancer?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Within the past ten years have you consulted any physician, received treatment or advice, or been prescribed medication, by any physician: for tumor, polyps, chest pain, palpitations, CVA (cerebro-vascular accident/stroke), TIA (transient ischemic attacks), diabetes, kidney disease, hepatitis, or for any disorder of the liver or colon, AIDS or a positive HIV test, angina or heart attack?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Are you aware of any symptoms or complaints regarding your health for which you have not yet consulted a physician or received treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you been advised to have further examination, diagnostic testing, treatment or surgery that has not yet been scheduled or completed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. In the past five years, have you used any narcotics, cocaine or other illegal drugs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Does your weight exceed the weight corresponding to your height in the following table?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Height		Weight	
ft/in	cm	lb	kg
4' 10"	145	158	71
4' 11"	148	163	74
5' 0"	150	169	77
5' 1"	153	174	79
5' 2"	155	182	83
5' 3"	158	188	85
5' 4"	160	193	88
5' 5"	163	198	90
5' 6"	165	205	93
5' 7"	168	210	96
5' 8"	170	216	99
5' 9"	173	224	102

Height		Weight	
ft/in	cm	lb	kg
5' 10"	175	229	104
5' 11"	178	235	107
6' 0"	180	242	110
6' 1"	183	250	113
6' 2"	185	256	117
6' 3"	188	264	120
6' 4"	190	271	123
6' 5"	193	277	126
6' 6"	195	285	129
6' 7"	198	293	133
6' 8"	200	299	137
6' 9"	203	308	140

FAMILY DOCTOR INFORMATION

Name of Family Doctor: _____

Contact person if not the above: _____

Mailing address: _____

Telephone: _____

EXPLANATION/ANSWER TO ANY OF THE PRECEDING QUESTIONS IN THE AFFIRMATIVE (YES)

No. Explanation/Answer: _____

No. Explanation/Answer: _____

SIGNATURE	DATE	REP ID (CORP. USE ONLY)
	/ /	McGill Financial - 001

dd mm yyyy