APPLICATION FOR INDIVIDUAL TERM LIFE INSURANCE

TeachersLife™
Life is for living

Please print clearly in black or blue ink.

SECTION 1 Member Information – Educator

❍ *Mr.* ❍ *Mrs.* ❍ *Ms* ❍ *Dr.*

First Name:_____ Middle Initial(s):_____

Last Name:_____

Gender: ❍ *Female* ❍ *Male*

Home Address:_____

City:_____

Province:_____ Postal Code:_____

Home Tel: (_____)_____

Work Tel: (_____)_____

Email:_____

Employer:_____

Occupation:_____

Gross Annual Salary: $_____

Income from other Sources: $_____

Date of Birth:_____ M M / D D / Y Y Y Y

Country of Birth:_____

❍ *Single* ❍ *Married* ❍ *Common Law*

❍ *Non-smoker** ❍ *Smoker*

Member Information – Spouse/Family Member *(if applying for coverage)*

❍ *Mr.* ❍ *Mrs.* ❍ *Ms* ❍ *Dr.*

First Name:_____ Middle Initial(s):_____

Last Name:_____

Gender: ❍ *Female* ❍ *Male*

Home Address:_____

City:_____

Province:_____ Postal Code:_____

Home Tel: (_____)_____

Work Tel: (_____)_____

Email:_____

Employer:_____

Occupation:_____

Gross Annual Salary: $_____

Income from other Sources: $_____

Date of Birth:_____ M M / D D / Y Y Y Y

Country of Birth:_____

❍ *Single* ❍ *Married* ❍ *Common Law*

❍ *Non-smoker** ❍ *Smoker*

SECTION 2 Choose Your Product & Amount of Insurance Coverage *(age requirements* and minimum coverage apply)*

EDUCATOR	Amount
❍ Teachers Life Term 10	❍ $50,000 (minimum)
❍ Teachers Life Term 20	❍ $100,000
❍ Teachers Life Term 25	❍ $200,000
❍ Teachers Life PermaTerm 100	❍ Other_____

SPOUSE/FAMILY MEMBER *(if applying for coverage)*	Amount
❍ Teachers Life Term 10	❍ $50,000 (minimum)
❍ Teachers Life Term 20	❍ $100,000
❍ Teachers Life Term 25	❍ $200,000
❍ Teachers Life PermaTerm 100	❍ Other_____

SECTION 3 Optional Dependant Riders

EDUCATOR

Child Coverage (all children)

❍ $1.20/month for $5,000 coverage

❍ $2.40/month for $10,000 coverage

SPOUSE/FAMILY MEMBER

Grandchild Coverage (up to 6 grandchildren)

❍ $2.40/month for $5,000 coverage

❍ $4.81/month for $10,000 coverage

**** Look to the "Guide for Applying" for definition.***

Need help completing this application? Contact us toll free at 1 800 668-4229 or email us at insuring@teacherslife.com

SECTION 4 Payment Information

Upon approval you will be contacted by a Teachers Life representative with information on how to set up your payment account with VersaPay, this is for your privacy and security.
Please note that once approved, your policy will not be in force until your first payment is received.

SECTION 5 Name Your Beneficiary

EDUCATOR'S BENEFICIARY
Beneficiary Name:_____
Relationship:_____
Date of Birth:__M M / D D / Y Y Y Y_____
Status:❍ primary ❍ contingent ❍ trustee *(if applicable)*

EDUCATOR'S BENEFICIARY
Beneficiary Name:_____
Relationship:_____
Date of Birth:__M M / D D / Y Y Y Y_____
Status:❍ primary ❍ contingent ❍ trustee *(if applicable)*

SPOUSE / FAMILY MEMBER'S BENEFICIARY *(if applying for coverage)*
Beneficiary Name:_____
Relationship:_____
Date of Birth:__M M / D D / Y Y Y Y_____
Status: ❍ primary ❍ contingent ❍ trustee *(if applicable)*

SPOUSE / FAMILY MEMBER'S BENEFICIARY *(if applying for coverage)*
Beneficiary Name:_____
Relationship:_____
Date of Birth:__M M / D D / Y Y Y Y_____
Status: ❍ primary ❍ contingent ❍ trustee *(if applicable)*

SECTION 6 Information About Proposed Insured

	EDUCATOR	SPOUSE/FAMILY MEMBER *(if applying for coverage)*
1. Have you ever had an application or reinstatement for life, disability or critical illness declined, rated, postponed, cancelled or otherwise modified. If yes, provide details.	❍ Yes ❍ No	❍ Yes ❍ No
2. Have you engaged or are you planning to engage in any hazardous sports or have you flown other than as a fare paying passenger or do you intend to do so? If yes, provide details. (e.g., auto racing, scuba diving, parachuting, sky diving, ultra-light, hand-gliding, mountaineering, bungee-jumping, automotive sports, etc.)	❍ Yes ❍ No	❍ Yes ❍ No
3. During the last three (3) years, have you: a) had your drivers license suspended or have your been found guilty of two (2) or more moving violations?	❍ Yes ❍ No	❍ Yes ❍ No
b) been convicted of impaired driving or of refusing to take a breathalyzer test? If yes to 3a) or 3b), provide details.	❍ Yes ❍ No	❍ Yes ❍ No
4. Have you ever received advice or treatment for alcohol or drug abuse or have your ever been advised to reduce your alcohol consumption? If yes, indicate when and state reason for the reduction.	❍ Yes ❍ No	❍ Yes ❍ No
5. Have you ever been convicted or accused of a criminal offence? If yes, provide details.	❍ Yes ❍ No	❍ Yes ❍ No
6. Within the past two years, have you traveled or resided outside of North American or are you planning to do so in the next 12 months? If yes, state countries, duration, and purpose.	❍ Yes ❍ No	❍ Yes ❍ No
7. Are you a Canadian citizen? If no, provide status.	❍ Yes ❍ No	❍ Yes ❍ No

Please provide details below to any question answered "yes" to above. If you need more space, please use a separate page and attach it to the application.

Question #:___Name:_____ Details:_____

Question #:___Name:_____ Details:_____

Question #:___Name:_____ Details:_____

Question #:___Name:_____ Details:_____

Question #:___Name:_____ Details:_____

Question #:___Name:_____ Details:_____

SECTION 7 Health Information and Questions *(Please answer ALL questions.)*

EDUCATOR

Physician's Name:_____

Tel: (_____)_____

Date Last Seen:_____ M M / D D / Y Y Y Y

Reason for Last Visit:_____

Results of Last Visit:_____

Height: _____ ❍ ft/in ❍ cm Weight: _____ ❍ lbs ❍ kg

SPOUSE/FAMILY MEMBER *(if applying for coverage)*

Physician's Name:_____

Tel: (_____)_____

Date Last Seen:_____ M M / D D / Y Y Y Y

Reason for Last Visit:_____

Results of Last Visit:_____

Height: _____ ❍ ft/in ❍ cm Weight: _____ ❍ lbs ❍ kg

Have you ever been told that you had suffered from or had any known indication or been treated for any of the following diseases, afflications or disorders or have you ever felt any symptoms?	EDUCATOR	SPOUSE/FAMILY MEMBER *(if applying for coverage)*
1. Within the past two (2) years, have you been hospitalized, unable to work for more than five (5) consecutive days, under observation, treated, or given medication, prescribed or non-prescribed, including over-the-counter medications such as vitamins, minerals, herbs, herbal medicine or any natural health products, counselling for any ailment other than minor ones (colds, flus, etc.), or advised to have a diagnostic test or see a specialist?	❍ Yes ❍ No	❍ Yes ❍ No
2. Have you ever had, been tested, treated, counseled or had any known indication of or been told or suspected you had any immune deficiency disorder, including AIDS or AIDS RELATED COMPLEX (ARC), positive HIV test (i.e., the AID test), or any test results indicating possible exposure to the AIDS virus, or any generalized enlargement of the lymphnodes or any unusual infection or immune system abnormality?	❍ Yes ❍ No	❍ Yes ❍ No
3. Have you ever had, been tested, treated, counseled or had any known indication of or been told you had any disturbance of (circle appropriate disorder): any heat or circulatory disorder, coronary artery disease or stroke, chest pains, high blood pressure, respiratory disorder (except for colds and flu), cancer, tumor or leukemia, disbetes, glandular disorder, mental or nervous disorder (depression , anxiety, stress, etc), multiple sclerosis or other neurological disorder, kidney disorder (except for kidney stones), ulcertative colitis, Crohn's disease, or other gastrointestinal disorder, hepatitus or other liver disorder, reproductive disorder, musculo-skeletal disorder, urinary abnormality, or other illness or injury?	❍ Yes ❍ No	❍ Yes ❍ No
4. Do you have any symptoms or health problems for which you have not consulted a doctor or been advised to undergo any tests whcih have not yet been performed or have you any condition for which hospitalization or surgery has been advised, or is contemplated within the next year?	❍ Yes ❍ No	❍ Yes ❍ No
5. Have you within the past 12 months smoked or used cigartettes, cigars, cigarillos, pipes, chewing tobacco, marijuana, hashish, snuff or any other nicotine based product, including gum and the patch?	❍ Yes ❍ No	❍ Yes ❍ No

Please provide details below to any questions answered "Yes" to above. If you need more space, please use a separate page and attach to the application.

Question #:_____ Applicant's Name:_____

Details:_____

_____

_____

Question #:_____ Applicant's Name:_____

Details:_____

_____

_____

Note: Teachers Life may request further medical information or medical tests at no cost to the applicant.

SECTION 8 Insurance Replacement Information

EDUCATOR

A. Is the policy applied for intended to replace any existing **Teachers Life** insurance plan?

❍ No ❍ Yes If "Yes", please indicate your Policy Number(s):

_____

_____

Note: If the policy applied for is intended to replace an existing life policy the owner must consent to the replacement. A replacement form will be issued by Teachers Life. This does not apply to Group or Creditor Insurance.

B. Is the policy applied for intended to replace/cancel any other existing insurance policy with another insurer?

❍ No ❍ Yes If "Yes", please indicate the following:

Insurer:_____ Policy Number_____

Type of Insurance: ❍ Term ❍ Whole Life ❍ Other_____

Amount: $_____ Issue Date:_____

SPOUSE/FAMILY MEMBER *(if applying for coverage)*

A. Is the policy applied for intended to replace any existing **Teachers Life** insurance plan?

❍ No ❍ Yes If "Yes", please indicate your Policy Number(s):

_____

_____

Note: If the policy applied for is intended to replace an existing life policy the owner must consent to the replacement. A replacement form will be issued by Teachers Life. This does not apply to Group or Creditor Insurance.

B. Is the policy applied for intended to replace/cancel any other existing insurance policy with another insurer?

❍ No ❍ Yes If "Yes", please indicate the following:

Insurer:_____ Policy Number_____

Type of Insurance: ❍ Term ❍ Whole Life ❍ Other_____

Amount: $_____ Issue Date:_____

SECTION 9 Terms and Conditions, Authorizations and Disclosures *(Please read carefully before signing.)*

Declaration — I, the applicant, hereby apply for insurance with Teachers Life Insurance Society (Fraternal). I declare that I am resident in Canada and at least 19 years of age. I declare that the statements contained in this application including the Health Information and Questions are true and complete. I understand that the application together with any other forms signed by me in connection with this application form the basis for any policy issued hereunder. I understand that any material misrepresentation, including misstatement of non-smoker status shall render the insurance voidable at the instance of the insurer and that suicide within 2 years of the effective date is not covered. I understand that insurance will take effect on the date my correctly completed application and any medical examinations or tests required are approved by Teachers Life, provided the first premium payment is received on or before that date.

Medical Information Bureau (MIB) — I hereby authorize Teachers Life Insurance Society (Fraternal) or its reinsurers to make a brief report to the Medical Information Bureau concerning any information collected for insurance purposes pursuant to this application and I further authorize the MIB to supply information from its files to any other member insurance company to which I have applied for life or health insurance or to which a claim is submitted. I also understand that I may request the MIB to disclose to me any information it may have in its files concerning coverage I may have under this plan and that I may contact the MIB to seek correction of any information in these files which I believe to be incorrect. The address for MIB's information office is: 330 University Avenue, Toronto, Ontario M5G 1R7 (telephone: 416 597-0590). I understand that the Medical Information Bureau is a non-profit membership organization of life insurance companies, which operates an insurance information exchange on behalf of its members.

Authorization and Revocation — I, the applicant to be insured, hereby authorize any licensed physician, medical practitioner, hospital, pharmacy, clinic or other medically licensed physician, medical practitioner, hospital, pharmacy, clinic or other medically related facility, insurance company, the MIB, any investigative or security agency, any agent, broker or market intermediary, any government agency or other organization or person that has any records or knowledge of me or my health to provide to Teachers Life Insurance Society (Fraternal) or its reinsurers any such information for the purpose of this application and contract and any subsequent claim. I authorize Teachers Life Insurance Society (Fraternal) to consult its existing files for this purpose.

I authorize Teachers Life Insurance Society (Fraternal), its subsidiaries, and affiliates to use this information to offer me their products and services, and I understand that my consent to the use of this information to offer me products and services is optional and that if I wish to discontinue such use, I may call or write to Teachers Life Insurance Society (Fraternal). I further authorize Teachers Life Insurance Society (Fraternal) to share the information contained in this application for member service purposes.

_____
(first, middle initial, surname - Please print)

X_____
EDUCATOR'S SIGNATURE **(Policy owner)**

_____
DATE

X_____
SPOUSE / FAMILY MEMBER SIGNATURE **(Policy owner)** *only applicable if applying for coverage.*

_____
DATE