TeachersLife

Pre-Screening Questionnaire for Critical Illness Applications

Name of Proposed Insured: _____ Date of Birth: MM ____ DD ____ YY ____
First Name Surname

Do not submit an application for critical illness if proposed insured has or had any of the following conditions. Please check "Yes" or "No" for each condition:

Condition	Yes	No	Condition	Yes	No
AIDS or AIDS related diseases, or tested positive for HIV	☐	☐	Polycystic Kidney Disease (PKD) or a family history of PKD if applicant is under the age of 35	☐	☐
Alzheimer's Disease	☐	☐	Insulin Dependent Diabetes	☐	☐
Angina	☐	☐	Major Organ Transplant	☐	☐
Benign Brain Tumour	☐	☐	Multiple Sclerosis	☐	☐
Cancer	☐	☐	Muscular Dystrophy	☐	☐
Chronic Kidney Failure	☐	☐	Parkinson's Disease	☐	☐
Coronary Artery Surgery	☐	☐	Hepatitis C	☐	☐
Cystic Fibrosis	☐	☐	Permanent Paralysis	☐	☐
Heart Attack	☐	☐	Stroke/TIA	☐	☐

TERMS, CONDITIONS, AUTHORIZATIONS, DISCLOSURES – Please read carefully before signing

I hereby declare that the above answers form an integral part of my application to Teachers Life, that they are full, complete and true, and that no circumstance which might affect my insurability, has been concealed. Failure to disclose every fact within the proposed insured's knowledge that is material to the insurance being applied for, or material to the insurability of the proposed insured, or any misrepresentation or misstatement of any facts, statements, information or answers given and contained in this pre-screening questionnaire shall render any insurance issued in connection with this application voidable by Teachers Life. I consent to the collection, use, and disclosure of the personal information provided in this form for the purpose determining my eligibility to apply for a critical illness policy in accordance with the terms of the Personal Information and Protection Electronic Documents Act (PIPEDA).

SIGNATURES

Proposed Insured's Signature _____ Date (dd/mm/yy) _____

Important Note:
If any members of the Proposed Insured's immediate family (i.e. siblings and natural parents) have had one of the above conditions, the policy may be rated or, in some cases, declined.

TeachersLife

APPLICATION FOR CRITICAL ILLNESS INSURANCE

Please print clearly in black ink.

1 PERSONAL INFORMATION OF PROPOSED INSURED

Surname	First Name	Middle Initial(s)	Please check appropriate title o Dr. o Miss o Mr. o Mrs. o Ms.
Address	City	Province	Postal Code
Home Telephone Number	Email Address		S.I.N.
Date of Birth (dd/mm/yy)	Place of Birth Province / State Country		Gender o Male o Female
Employer	Occupation (Administrator, Teacher, etc)		Member ID Number (if applicable)
Business Telephone Number	Gross Annual Salary		Income from other sources

2 POLICY INFORMATION

Coverage is available in blocks of $25,000. A minimum of $25,000 is required. A maximum of $250,000 is available.

Amount Applied For: _____

o Step Rate Premium Schedule, or o Level Rate Premium Schedule | o Standard Rates, or o Non-Smoker Rates

3 BENEFICIARY OF THIS POLICY

Select a Beneficiary as Appropriate	**Full Name of Eligible Beneficiary**	**Gender** (M or F)	**Relationship**	**Date of Birth** (dd/mm/yy)
☐ **Primary** ☐ **Contingent** ☐ **Trustee (*if applicable*)**				
☐ **Primary** ☐ **Contingent** ☐ **Trustee (*if applicable*)**				
☐ **Primary** ☐ **Contingent** ☐ **Trustee (*if applicable*)**				

The beneficiary of the policy is **ordinarily** the insured. However, in the event of a death claim resulting from a cause other than a covered Critical Illness or not surviving the survival period while this policy is in effect, the Society will pay to the stated beneficiary, **return of premiums as outlined in Part 11 (a) (90 day exclusion period for the discovery of cancer) or Part 11 (d) (death from a cause other than for covered critical illnesses).**

4 DECLARATION OF INSURABILITY

Name and address of your personal physician:

Physician's Telephone Number ( )

Please answer the following health questions. Provide full details to all "Yes" answers in the white space provided on this page, indicating conditions, dates, duration, results, names and addresses of doctors, clinics, etc. Number the answers to correspond to the questions.

	Yes	**No**	**Explanation**
1) Have you ever had any application for life, disability or critical illness insurance declined, postponed, cancelled, rescinded, rated, modified or issued other than applied for in any way? 2) Other than this application, is there any Critical Illness Insurance currently in force or pending? If "Yes", provide, company name, amount, plan name, policy number.			
3) Have you ever been tested, treated, been diagnosed, received treatment, consulted a physician or other health care practitioner, been referred to any specialist, had any investigation or been prescribed medication for: **a)** tumors, polyps, chest pains, palpitations, TIA (Transient Ischemic Attacks), diabetes, kidney disease, eye (excluding corrective lenses) and/or ear disorder, hepatitis, or any disorder of the liver or colon, or a positive HIV test or any neurological disorder? Or, **b)** had any abnormal PSA (Prostate Specific Antigen) tests or an abnormal mammogram or pap smear? 4) Are there any health problems or symptoms for which the proposed insured is planning to seek medical advice?			

	Yes	No	Explanation
5) **FAMILY HISTORY:** Has any of your first-degree relatives (natural parents, brothers, or sisters), either living or dead, ever suffered from the following conditions: diabetes, stroke, heart disease, cancer, kidney disease, multiple sclerosis, Alzheimer's disease, or any inherited disease?			

Family Member: Relationship and Name	Condition	Age at Onset	Age if Living	Age at Death	Cause of Death

6) Have you used any form of tobacco in the last 12 months including cigarettes, cigarillos, cigars, pipes, chewing tobacco, marijuana, hashish, snuff, or any other nicotine based product? o Yes o No Please explain.

5 TERMS, CONDITIONS, AUTHORIZATIONS, DISCLOSURES – PLEASE READ CAREFULLY BEFORE SIGNING

Authorization

I, as the proposed insured or policyowner (if applicable), hereby authorize any physician, health care professional, any insurance company, the Medical Information Bureau, my employer, or any other organization, institution or person that has any records or knowledge my health or other information relevant to the purposes set out below**,** to provide full particulars of such information, including prior medical history, to Teachers Life or its reinsurers for the purpose of assessment of the insurance risk for underwriting purposes, administration, and investigations necessary to adjudicate any claim or assess the validity of the policy as issued.

I further authorize Teachers Life's medical service providers to perform such tests, examinations, x-rays, electrocardiograms, and blood tests as may be required to underwrite this application for insurance and to disclose such results to Teachers Life. Such tests may include tests to determine the presence or absence of various diseases, including the antibodies or virus related to Acquired Immunodeficiency Syndrome (AIDS), and Teachers Life may release the results of these tests and examinations to its reinsurers, my attending Physician(s), and the Medical Information Bureau.

I agree that in order to enable Teachers Life to improve its services to members, to maintain and develop its relationship with me, and to better ensure I am advised on Teachers Life's membership benefits, products and services that may be available to me, I authorize Teachers Life, its partners and its service providers, to collect and use personal information about me for internal marketing purposes. As acknowledged in Teachers Life's Privacy Policy, I may inform Teachers Life, at any time, to stop using my personal information.
I also understand that restricting the use of my personal information may prevent me from learning of benefits, services and products that could be of value to me.
I further consent to the collection, use, and disclosure of the personal information provided in this form for the purpose described above in accordance with the terms of the Personal Information and Protection Electronic Documents Act (PIPEDA).

A COPY OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL.

Payment Authorization

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.

Acknowledgment

I acknowledge that I have read and understood the Medical Information Bureau Pre-Notice, the Consumer Notice concerning personal investigation or consumer reports and the Important Notice Concerning Files and Personal Information.

Declaration

I, the undersigned proposed insured or policyowner (if applicable), hereby apply for insurance to Teachers Life. I declare that I am a resident of Canada and at least 18 years of age. I hereby declare that the above answers and statements form an integral part of my application to Teachers Life, that they are full, complete and true, and that no circumstance which might affect my insurability, has been concealed. Failure to disclose every fact within the proposed insured's knowledge that is material to the insurance being applied for, or material to the insurability of the proposed insured, or any misrepresentation or misstatement of any facts, statements, information or answers given and contained in this application, or any Part II shall render any insurance issued in connection with this application voidable by Teachers Life. Benefits, in the case of suicide within two years of the effective date of any coverage, are restricted to the return of premiums only. I understand that the insurance will take effect when this application has been approved by Teachers Life, if I, the proposed insured, am alive and my insurability remains unchanged on the date the policy comes into force, and premium payment has been received. I declare that I am eligible in accordance with the eligibility criteria set out by Teachers Life and have read this section of the application. I have also read and answered all of the questions carefully.

Declaration on Replacement

I acknowledge that I have read and understood the policy replacement information and that Teachers Life may decline an application that indicates a replacement is intended.

6 SIGNATURES

Signature of Proposed Insured_____ Date (dd/mm/yy) _____

Please send completed form to:
Teachers Life Insurance Society (Fraternal)™
916 The East Mall, Toronto, ON, M9B 6K1
Tel: (416) 620-1140 1-800-668-4229 Fax: (416) 620-6993 Email: insuring@teacherslife.com www.teacherslife.com

TeachersLife™

Application Disclosure for Critical Illness Insurance

PLEASE SEPARATE THIS SHEET FROM THE APPLICATION FORM AND KEEP IT FOR YOUR RECORDS

DISCLOSURE NOTICES

Medical Information Bureau Pre-Notice

Personal information regarding your insurability, including medical information, will be treated as confidential and used to provide you with insurance services, or to offer you other services. However, Teachers Life or its reinsurers may make a brief report to the Medical Information Bureau, a not-for-profit membership organization of life insurance companies that operate an information exchange on behalf of its members. If you apply to another member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Medical Information Bureau will supply that company, upon request, with any information it may have in its files.

The Bureau will also arrange for the release, at your request, of any information that it may have about you (medical information will be given only to your physician). If you question the accuracy of information in the Bureau's files, you may contact the Bureau and seek a correction. The address of the Bureau's information office is:

MIB Information Office
330 University Avenue
Toronto, ON M5G 1R7
Telephone: (416) 597-0590

Teachers Life, its reinsurers, or its mandataries may also release information in its file to other life insurance companies to whom you may apply for health insurance, or to whom a claim for benefits has been submitted.

Consumer Notice

In the processing of the application for insurance, Teachers Life may also obtain a personal investigation or consumer report containing personal information about the applicant.

IMPORTANT NOTICE CONCERNING FILES AND PERSONAL INFORMATION

In order to ensure the confidentiality of the personal information held concerning you, Teachers Life will establish a life and health insurance file in which the information concerning your application for insurance will be placed, as well as the information concerning any insurance claim.

Only Teachers Life employees, who will be responsible for underwriting, administration, investigation, adjudication and claim payment, or any other person authorized by you, or by law, will have access to your file.

Your file will be kept in the company's offices. You are entitled to consult your personal information contained in the file and, if applicable, have it rectified by submitting a written request to the address below. However, if there is medical information in your file that was not given directly by you, we may require that this information be released only to your own doctor.

For more detailed information, please refer to the privacy brochure on our website or call our office to obtain a copy.

Teachers Life Insurance Society (Fraternal)
Attn: Access Officer
916 The East Mall
Toronto, ON M9B 6K1
www.teacherslife.com