Teachers Life

Individual Term Life Insurance | Application

Section 1 - Applicant Information

Applicant

○ Mr. ○ Mrs. ○ Ms. ○ Dr.

First Name: _____ Middle Initial(s): ____

Last Name: _____

Gender: ○ Female ○ Male

Home Address: _____

City: _____

Province: _____ Postal Code: _____

Contact Number: (_____)_____

Email: _____

Employer: _____

Occupation: _____

Gross Annual Salary: $_____

Income From Other Sources: $_____

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

Country of Birth: _____

Status: ○ Single ○ Married ○ Common Law

○ Non-smoker ○ Smoker

Spouse/Family Member

○ Mr. ○ Mrs. ○ Ms. ○ Dr.

First Name: _____ Middle Initial(s): ____

Last Name: _____

Gender: ○ Female ○ Male

Home Address: _____

City: _____

Province: _____ Postal Code: _____

Contact Number: (_____)_____

Email: _____

Employer: _____

Occupation: _____

Gross Annual Salary: $_____

Income From Other Sources: $_____

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

Country of Birth: _____

Status: ○ Single ○ Married ○ Common Law

○ Non-smoker ○ Smoker

Section 2 - Choose Your Coverage (age requirements and minimum coverage apply)

Applicant	Amount	Spouse/Family Member	Amount
	○ $10,000 (PermaTerm 100 only)		○ $10,000 (PermaTerm 100 only)
○ Term 10	○ $50,000	○ Term 10	○ $50,000
○ Term 20	○ $100,000	○ Term 20	○ $100,000
○ Term 25	○ $200,000	○ Term 25	○ $200,000
○ PermaTerm 100	○ Other: _____	○ PermaTerm 100	○ Other: _____

Section 3 - Child/Grandchild Benefit (optional)

YES! I would like to include:

Child Coverage (all children)

○ $1.20/month for $5,000 coverage

○ $2.40/month for $10,000 coverage

Grandchild Coverage (up to 6)

○ $2.40/month for $5,000 coverage

○ $4.81/month for $10,000 coverage

Section 4 - Payment Information

Once approved you will be contacted by a Teachers Life representative via email 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 - Beneficiary

If your beneficiary is a minor, state the name of a trustee, e.g., "John Smith, in trust for Mary Smith." Unless indicated in writing, your beneficiary is your estate. For definitions, please see below.

Applicant's Beneficiary

Beneficiary Name: _____

Relationship: _____

Date of Birth: M M / D D / Y Y Y Y Gender: ○ Female ○ Male

Status: ○ Primary ○ Contingent ○ Trustee (if applicable)

Beneficiary Name: _____

Relationship: _____

Date of Birth: M M / D D / Y Y Y Y Gender: ○ Female ○ Male

Status: ○ Primary ○ Contingent ○ Trustee (if applicable)

Spouse/Family Member's Beneficiary

Beneficiary Name: _____

Relationship: _____

Date of Birth: M M / D D / Y Y Y Y Gender: ○ Female ○ Male

Status: ○ Primary ○ Contingent ○ Trustee (if applicable)

Beneficiary Name: _____

Relationship: _____

Date of Birth: M M / D D / Y Y Y Y Gender: ○ Female ○ Male

Status: ○ Primary ○ Contingent ○ Trustee (if applicable)

Primary Beneficiary: The party designated to receive the proceeds of a life insurance policy following the death of the insured. Also known as first beneficiary.

Contingent Beneficiary: The party designated to receive the proceeds of a life insurance policy following the insured's death if the primary beneficiary should die before the insured. Also known as the secondary beneficiary or successor beneficiary.

Trustee: A person who holds legal title to property for the benefit of another, e.g., for a minor who is under 18 years of age.
Note: It is prudent to consult a lawyer before appointing a Trustee.

Section 6 - Information about Proposed Insured

	Applicant	Spouse/Family Member
1. Have you ever had an application or reinstatement for life, disability or critical illness insurance declined, rated, postponed, cancelled or otherwise modified? If yes, provide details below.	○ 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? (e.g., auto racing, scuba diving, parachuting, sky diving, ultra-light, hang-gliding, mountaineering, bungee-jumping, automotive sports, etc.) If yes, provide details below.	○ Yes ○ No	○ Yes ○ No
3. During the past three (3) years, have you a) had your driver's licence suspended or have you been found guilty of two (2) or more moving violations? b) been convicted of impaired driving or of refusing to take a breathalyzer test? If yes to 3a) or 3b), provide details below.	○ Yes ○ No	○ Yes ○ No
4. Have you ever received advice or treatment for alcohol or drug abuse or have you ever been advised to reduce your alcohol consumption? If yes, indicate below when and state reason for the reduction.	○ Yes ○ No	○ Yes ○ No
5. Have you ever been convicted of or charged with a criminal offence? If yes, provide details below.	○ Yes ○ No	○ Yes ○ No
6. Within the past two (2) years, have you travelled or resided outside of North America or are you planning to do so in the next 12 months? If yes, state countries, duration and purpose below.	○ Yes ○ No	○ Yes ○ No
7. Are you a Canadian citizen? If no, provide status below.	○ Yes ○ No	○ Yes ○ No

If you answered "Yes" to questions 1–6 or "No" to question 7, please provide details. If you need more space, please use a separate page and attach to the application.

Question #: _____ Name: _____ Details: _____

Question #: _____ Name: _____ Details: _____

Section 6 - Information about Proposed Insured (continued)

Question #: _____ Name: _____ Details: _____

Question #: _____ Name: _____ Details: _____

Section 7 - Health Information and Questions (please answer ALL questions)

Applicant

Physician's Name: _____

Physician's Phone Number: (_____)_____

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

Reason for Last Visit: _____

Results for Last Visit: _____

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

Spouse/Family Member

Physician's Name: _____

Physician's Phone Number: (_____)_____

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

Reason for Last Visit: _____

Results for Last Visit: _____

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

	Applicant	Spouse/Family Member
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 or counselled for; 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 AIDS test) or any test results indicating possible exposure to the AIDS virus, or any generalized enlargement of the lymph nodes or any unusual infection or immune system abnormality?	○ Yes ○ No	○ Yes ○ No
3. Have you ever had; been tested, treated or counselled for; had any known indication of or been told you had any disturbance of (circle appropriate disorder): any heart or circulatory disorder, coronary artery disease or stroke, chest pains, high blood pressure, respiratory disorder (except for colds and flu), cancer, tumour, leukemia, diabetes, glandular disorder, mental or nervous disorder (depression, anxiety, stress, etc.), multiple sclerosis or other neurological disorder, kidney disorder (except for kidney stones), ulcerative colitis, Crohn's disease or other gastrointestinal disorder, hepatitis 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 have you been advised to undergo any tests that have not yet been performed, or do you have 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 cigarettes, 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" above. If you need more space, please use a separate page and attach to the application.

Question #: _____ Name: _____ Details: _____

NOTE: Teachers Life may request further medical information or medical tests at not cost to the applicant.

Section 8 - Family History

Do you know if any of your natural parents, brothers or sisters have been diagnosed with, or died from, any of the following, before age 60:

	Applicant	Spouse/Family Member
1. Angina, heart attack or coronary thrombosis, cardiomyopathy, blocked or narrowed coronary arteries, coronary artery bypass or stent insertion?	○ Yes ○ No	○ Yes ○ No
2. Stroke or brain hemorrhage?	○ Yes ○ No	○ Yes ○ No
3. Diabetes?	○ Yes ○ No	○ Yes ○ No
4. Breast, ovarian, colon or bowel cancer or cancer of another site, including lymphoma?	○ Yes ○ No	○ Yes ○ No
5. Familial adenomatous polyposis (FAP) / polyposis coli?	○ Yes ○ No	○ Yes ○ No
6. Multiple sclerosis, motor neuron disease, Huntington's disease, Alzheimer's disease, polycystic kidney disease or porphyria?	○ Yes ○ No	○ Yes ○ No

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

Question #: _____ Name: _____ Details: _____

_____

Section 9 - Insurance Replacement

Applicant

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

○ No ○ Yes If "Yes," please indicate our 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 our Policy Number(s):

Insurer: _____ Policy No.: _____

Type of Insurance: ○ Term ○ Whole ○ Life ○ Other: _____

Amount: $ _____ Issue Date: M M / D D / Y Y Y Y

Spouse/Family Member

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

○ No ○ Yes If "Yes," please indicate our 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 our Policy Number(s):

Insurer: _____ Policy No.: _____

Type of Insurance: ○ Term ○ Whole ○ Life ○ Other: _____

Amount: $ _____ Issue Date: M M / D D / Y Y Y Y

Section 10 - Authorizations

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 two (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.

MIB – Information regarding your insurability will be treated as confidential. Teachers Life or its reinsurers may, however, make a brief report thereon to MIB, Inc., a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Section 10 - Authorizations (continued)

Upon receipt of a request from you MIB will arrange disclosure of any information it may have in your file. Please contact MIB at (416) 597-0590. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 330 University Avenue, Suite 501, Toronto, Ontario, Canada, M5G 1R7."

Teachers Life, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

Authorization – I, the applicant to be insured, hereby authorize any licensed physician, medical practitioner, hospital, pharmacy, clinic or other medically licensed related facility, insurance company, 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) to make a brief report to MIB.

I consent to the collection, use, and disclosure of personal information declared on this form for the purposes of applying for conversion of my existing policy in accordance with the terms of the Personal Information Protection and Electronic Documents Act (PIPEDA).

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.

Section 11 - Signatures

By signing below I acknowledge that I have read, understood and agree to all of the above.

Applicant Signature: _____ Date: M M / D D / Y Y Y Y

Applicant Signature: _____ Date: M M / D D / Y Y Y Y

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

Please send completed form to:
Teachers Life Insurance Society (Fraternal)™
916 The East Mall, Suite C,
Toronto, ON, M9B 6K1
416-620-1140 | Toll Free 1-800-668-4229 | Fax 416-620-6993
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teacherslife.com