



TEACHERS LIFE
Ready For Life

Application for Membership and Insurance with
Teachers Life Insurance Society (Fraternal)
LATE ENTRANT
EDUCATOR'S INCOME PROTECTION PLAN
Toronto District 12 OSSTF

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

ELIGIBILITY CRITERIA - DISABILITY INSURANCE

This application is for the Educator's Income Protection Plan (EIPP), a percentage of salary disability plan for the Toronto District 12 secondary school teachers. Please read the following eligibility criteria carefully.

Eligibility

To obtain coverage the insured must be:

1. Actively employed as a teacher in a secondary school or related facility of the Toronto District School Board.
2. Making regular contributions to a recognized pension plan like the Ontario Teachers' Pension Plan.

"Actively Employed" means being physically and mentally capable of performing the customary duties of the individual's regular job for the scheduled number of hours for that day and must be actually working for a minimum of 20 hours or more per week at the Employer's place of business where the Employer requires the individual to work and performing the individual's duties.

Necessary Information

1. If the proposed insured is not currently a member of Teachers Life, a copy of his/her birth certificate or any other acceptable proof of age must be enclosed.
2. The proposed insured must submit proof of income by enclosing a photocopy of his/her pay stub.
3. Depending on the proposed insured's age and the amount of insurance being applied for, certain medical requirements may be necessary.
4. All applicable sections of this application form must be completed. Failing to complete all sections could result in this application being returned and approval being delayed.
5. If any corrections are made to this application, they must be initialed by the proposed insured.
6. Any statements attached to the application and made by the proposed insured must be signed and dated.

IMPORTANT DISCLOSURE 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 and you are entitled to consult your personal information contained in the file and, if applicable, to 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: Privacy Officer
916 The East Mall, Suite C
Toronto, ON M9B 6K1
www.teacherslife.com

TEACHERS LIFE INSURANCE SOCIETY (FRATERNAL)

PLEASE READ CAREFULLY BEFORE COMPLETION OF APPLICATION: For the policy or any upgrade to take effect, your insurability must remain unchanged from the date you sign your application to the policy issue date. You must also be actively working according to the definition in the Policy from the date you sign your application up to and including the policy issue date.

1 PERSONAL INFORMATION

Surname	First Name	Middle Initial(s)	Title <input type="radio"/> Dr. <input type="radio"/> Miss <input type="radio"/> Mr. <input type="radio"/> Mrs. <input type="radio"/> Ms
Address	City	Province	Postal Code
Email Address	Home Telephone Number	Gender <input type="radio"/> Male <input type="radio"/> Female	TDSB Employee Number
Marital Status <input type="radio"/> Common Law <input type="radio"/> Married <input type="radio"/> Single	Date of Birth (dd/mm/yy)	Occupation	
Gross Annual Salary	Start Date of Employment (dd/mm/yy)	Income From Other Sources	

2 EMPLOYMENT INFORMATION

Employer (Board of Education, Federation, etc.)	Subject Taught
Location of Employment (School, Office)	Address
City	Postal Code
	Business Telephone Number

1) Are you currently and have you always been actively teaching/employed in an educational capacity under contract on a full-time basis? Yes No

If no, answer questions 2 and 3.

2) What proportion of a full-time position are you currently employed (i.e. 100%, 50%, 33%...)? _____ %

3) Provide details, including beginning and ending dates, of when you have been actively teaching/employed in an educational capacity under contract on less than a 100% timetable? **(Note that periods of time not mentioned, will be assumed to have been taught on a 100% timetable.)**

4 a) How many days of sick leave credit have you accumulated in Ontario (up to and including September 1 of the current school year)? _____

b) If you have used, on average, more than six (6) sick days per year, please explain below.

5 b) In Ontario, I have been teaching/employed in an educational capacity or by a federation for _____ years (up to and including September 1st of the current school year).

3 POLICY INFORMATION DISABILITY

Please check the level of coverage for which you are applying. You may choose from one of the options below. The benefit level and the cost of living adjustment chosen will determine your total annual premium. **Premium costs expressed below are a percentage of your gross salary.**

Benefit Level Option	45%				50%				55%			
	0%		2%		0%		2%		0%		2%	
C.O.L.A. Option (%)	Annual Premiums (%)											
Waiting Periods 3 months 6 months End of sick leave*	TDSB Level	TDSB Level	TDSB Level	TDSB Level	TDSB Level	TDSB Level	TDSB Level	TDSB Level	TDSB Level	TDSB Level	TDSB Level	TDSB Level
	0 1.49	1	0 1.57	10	0 1.71	4	0 1.80	13	0 1.92	7	0 2.03	16
	0 1.30	2	0 1.37	11	0 1.49	5	0 1.57	14	0 1.68	8	0 1.77	17
	0 1.03	3	0 1.08	12	0 1.18	6	0 1.24	15	0 1.33	9	0 1.40	18

*3 calendar months or the end of sick leave, whichever is later (to a maximum of 220 working days).

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4 CURRENT COVERAGE INFORMATION

1) Describe below all of your in force life, disability or critical illness insurance and indicate if individual or group insurance. If you do not have any life, critical illness or disability insurance, write in "none".

Company Name	Issue Date (dd/mm/yy)	Life Insurance Amounts	Disability Amounts	Critical Illness Amounts	Benefit Period

DO NOT CANCEL an existing policy until confirmation of approval from the Society has been received.

5 OTHER INFORMATION RELATIVE TO THE APPLICATION FOR INSURANCE

	Yes	No
1) Have you any other applications for life, disability, or critical illness insurance now pending or contemplated with another company?		
2) Have you ever had an application for life, disability, or critical illness insurance declined, rescinded, postponed, rated or modified in any way, or any such policy of insurance canceled or renewal refused by any company?		
3) Have you ever applied for, received or been refused benefits, settlements, or pension (including workers' compensation or government benefits) because of an injury, sickness or disability?		
4) In the next five (5) years, do you intend to travel or live outside of Canada or the United States for any length of time, or change your occupation?		
5) Have you ever engaged in or do you intend to engage in any hazardous sports such as motorcycle riding, ATV (all terrain vehicle) use, scuba diving, bungee jumping, parachute, karate, judo, hang-gliding, motor vehicle or motorboat racing, rodeo activities, heli-skiing, mountain climbing or any other sport or avocation? If "Yes", specify below.		
6) Have you ever flown as a pilot, student pilot, or piloted a jet, ultralight or glider, or served as a crew member, or do you intend to take flying lessons, or fly other than as a fare-paying passenger?		
7) Have you ever had your driver's license suspended or revoked, been convicted of, or have charges pending for any moving traffic violation, e.g. speeding, impaired, or careless driving, etc.? If "Yes", complete the following and provide dates and details below. License No. _____ Province _____		
8) Have you ever been convicted of a criminal offence, or are criminal charges currently pending against you? If "Yes", give dates and describe the nature of conditions and charges in the space provided below.		
9) Have you ever faced disciplinary action or received 2 or more unsatisfactory performance reviews from your professional licensing body, or had your professional license suspended or restricted? If "Yes", give dates and details in the space provided below.		
10) If you answered "Yes" to questions 1 to 7 provide details in the space provided below.		

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6 STATEMENT OF HEALTH

1a) Name and address of your personal physician:	b) Physician's Telephone Number:	c) How long have you been going to this physician?
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d) Dates of visits in the last six (6) months:	e) Reason consulted and outcome, including medications:
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f) If no visits in the last six (6) months, indicate date of last visit:	g) Reason consulted and outcome, including medications:
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2a) Height (ft/in/cm)	b) Weight (without shoes in lb/kg)	c) How much has weight changed in past year? _____ <input type="radio"/> Gain <input type="radio"/> Loss <input type="radio"/> No Change
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d) Give reasons for any change in weight.

3) **FAMILY HISTORY**
 Has any member of your immediate family ever had diabetes, high blood pressure, stroke, genetic or hereditary disorders, heart disease, kidney disease, cancer, multiple sclerosis, motor neuron disease (ALS), Huntington's disease, hemophilia, neurological or psychiatric illness or alcohol abuse? Yes No If "Yes", please provide details in the chart below:

Please Indicate:	Condition	Age at Onset	Age if Living	State of Health if living	Age at Death	Cause of Death
Mother						
Father						
<input type="radio"/> Sister <input type="radio"/> Brother						
<input type="radio"/> Sister <input type="radio"/> Brother						

Please answer the following health questions. Provide full details to all "Yes" answers on page 5, indicating conditions, dates, duration, results, names and addresses of doctors, clinics, etc. Number the answers to correspond to the questions.

	Yes	No
4) FEMALES ONLY		
a) Are you pregnant or suspect you might be? If "Yes", give due date (dd/mm/yy): _____		
b) Have you ever had any complications of pregnancy or childbirth?		
c) Have you ever had a cesarean section?		
d) Have you ever had endometriosis or any disorder of reproductive organs including breasts?		

Have you ever had, been tested, treated, counseled, or had any known indication of, or been told you had:

	Yes	No
5) Any Immune Deficiency Disorder, Acquired Immune Deficiency Syndrome (AIDS) or AIDS RELATED COMPLEX (ARC), positive HIV test (i.e. the AIDS test), or any tests results indicating possible exposure to the AIDS virus?		
6) Enlarged lymph nodes (glands), chronic diarrhea, weight loss, unusual skin lesions, unexplained infections or fevers?		
7) High blood pressure, chest pain or discomfort, shortness of breath, palpitations, heart murmur, rheumatic fever, angina, heart attack, or other problems with the heart or circulatory system?		
8) Elevated cholesterol, triglycerides or blood sugar?		
9) Dizziness, epilepsy, fainting, recurrent headaches, migraines, convulsions, paralysis, stroke or other disorder of the brain or nervous system?		

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6 STATEMENT OF HEALTH (continued)

Have you ever had, been tested, treated, counseled, or had any known indication of, or been told you had:	Yes	No
10) Any amputation, partial or total loss of vision, impaired hearing, disease or disorder of the eyes, ears or speech?		
11) Asthma, bronchitis, tuberculosis, pneumonia, allergies, emphysema, shortness of breath, blood spitting, persistent cough or other disorder of the lungs or respiratory system, or throat disorder?		
12) Skin disorder, including allergies?		
13) Cysts, polyps, tumor, cancer or any other growth?		
14) Diabetes, thyroid or endocrine disorder?		
15) Anemia or any disorder of the blood or bone marrow?		
16) Phlebitis, varicose veins, swelling of feet or legs, clotting disorder, or other disorder of blood vessels?		
17) Sugar, albumin, protein, blood or pus in urine, nephritis, kidney stone or other disorder of kidney or bladder?		
18) Colitis, chronic diarrhea, hernia, ulcer, cirrhosis, or any disease of the digestive system including mouth, esophagus, stomach, intestines, rectum, liver, pancreas or gall bladder?		
19) Back, neck or spinal discomfort including pain, sprain, strain, sciatica, disc disease or had therapeutic massage or chiropractic treatment?		
20) Arthritis, rheumatism, fibrositis, carpal tunnel syndrome, gout or any other disorder of the muscles, tendons, bones or joints, or connective tissue disease?		
21) Sexually transmitted disease or any disease or disorder of the reproductive organs?		
22) Have you ever had a transfusion of blood or blood products?		
23) Have you ever tested positive for hepatitis and/or been told you were a carrier?		
24) Have you ever been immunized against hepatitis B?		
25) Have you ever had, been tested, treated, counseled, or had any known indication of, or been told you had: depression, fatigue or burnout, anxiety, stress, chronic fatigue, fibromyalgia, chronic pain syndrome or any other emotional, behavioural, mental or nervous disorder?		
26) Except prescribed by a physician, have you ever used drugs, barbiturates, narcotics, sedatives, hallucinogens, tranquilizers, L.S.D., cocaine, marijuana or any other substance?		
27) Do you now use or have you ever used alcoholic beverages? If "Yes", number of drinks per week:		
28) Have you ever received or been advised to receive counseling, treatment or attended an organization because of personal alcohol or substance abuse?		
29) During the last 30 days, have you worked in your regular occupation less than your usual number of hours per week because of sickness or injury?		
30) Have you ever lost more than 15 days at any one time from work or been disabled because of accident or illness?		
31) Are you now experiencing any symptoms, disease, disorder or condition which might require surgery, impair your health or your ability to work (now or in the future) or for which you plan to consult a physician?		
32) Are you currently on any medication, prescribed or non-prescribed, including over-the-counter medications such as vitamins, minerals, herbs, herbal medications, or any other natural health products? If "Yes", indicate: type and name, dose frequency of use, length of time taking and reason for taking the medication or product.		
33) Other than already mentioned in this application, within the past five (5) years, have you consulted a physician, psychiatrist, psychologist, counselor, marital or family counselor, chiropractor or other health practitioner?		
34) Have you had or been advised to have an electrocardiogram (EKG or ECG), x-ray, blood tests, any diagnostic test, procedure, hospitalization or surgery?		
35) Any other condition not covered above? If "Yes", please state condition(s) and provide information on page 5.		

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9 THREE MONTHS SURVIVOR BENEFITS DESIGNATION

Since your policy has survivor benefits, it is necessary to name a beneficiary for your plan. If your beneficiary is a minor, state the name of a trustee, e.g. "John Doe, in trust for Mary Smith". Your trustee should not be listed as a beneficiary. Unless indicated in writing, your beneficiary is your estate.

Beneficiary Name: _____	Beneficiary Name: _____
Relationship: _____	Relationship: _____
Date of Birth: _____	Date of Birth: _____
Gender: <input type="radio"/> Female <input type="radio"/> Male	Gender: <input type="radio"/> Female <input type="radio"/> Male
Status: <input type="radio"/> primary <input type="radio"/> contingent <input type="radio"/> trustee (if applicable)	Status: <input type="radio"/> primary <input type="radio"/> contingent <input type="radio"/> 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.
Jones, H.E. Principles of Life Insurance: Life, Health, and Annuities 2005.

If you have more than two beneficiaries please provide additional names and information on a separate sheet of paper and attach to this application.

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

Authorization

I, as the proposed insured, hereby authorize any physician, health care professional, any insurance company, my employer, or any other organization, institution or person that has any records or knowledge of my health or other information relevant to the purposes set out below, to provide full particulars of such information, to Teachers Life 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 disclose such test 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 your attending Physician(s).

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 disclosed 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

I hereby authorize and direct Teachers Life to arrange premium payments for my disability policy by payroll deductions as established by my employer. If my payroll deductions cease for any reason, I must arrange for an alternate form of payment.

Acknowledgment

I acknowledge that I have read and understood the attached Important Disclosure Notice Concerning Files and Personal Information.

Declaration

I, the undersigned proposed insured 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 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.

11 SIGNATURE – Please sign, date and return this form to our office

Signature of Insured _____ Date (dd/mm/yy) _____

Please return to this application to Teachers Life. It can be delivered to us by email, fax or letter mail.

Email to: insuring@teacherslife.com

Fax to: (416) 620-6993

Or Mail to: 916 The East Mall, Suite C, Toronto, ON, M9B 6K1