



**TEACHERS LIFE**  
*Ready For Life*

Application for Membership in and Insurance with  
Teachers Life Insurance Society (Fraternal)

**PEEL DISABILITY INSURANCE PLAN**

**Upgrade Application**

## ELIGIBILITY CRITERIA – PEEL DISABILITY INSURANCE PLAN

This application is for the Peel 2005 Disability Insurance Plan. Please read the following eligibility criteria carefully.

### Eligibility

The insured must be:

1. Actively employed\* as an educator in a school or related facility of the Peel District School Board.
2. Actively employed\* in the administration of a school or related facility of the Peel District School Board.
3. Actively employed\* with a teachers' federation or other recognized teachers' organizations or associations affiliated with the Ontario Teachers' Federation.
4. Making regular contributions to the Ontario Teachers' Pension Plan or to an approved 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. Depending on the proposed insured's age and the amount of insurance being applied for, certain medical requirements may be necessary.
2. 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.
3. If any corrections are made to this application, they must be initialed by the proposed insured.
4. Any statements attached to the application and made by the proposed insured must be signed and dated.
5. The proposed insured's signature must be witnessed by someone other than the spouse or the beneficiary of the policy being applied for.
6. The proposed insured's signature must submit proof of income by enclosing a copy of the most recent paystub.

### 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](http://www.teacherslife.com)

**PLEASE PRINT CLEARLY IN BLACK INK**

**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)	Please check appropriate 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
Home Telephone Number	Email Address	Member ID Number (if applicable)		
Date of Birth (dd/mm/yy)	Gross Annual Salary	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		

**2 EMPLOYMENT INFORMATION**

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

1. Are you currently actively at work on a full-time basis?

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2. Have you always been actively teaching/employed in an educational capacity under contract on a full-time basis?  
If no, answer questions 2 and 3.

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

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4. 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.)**

- 5 a) How many days of sick leave credit have you accumulated in Ontario **(up to and including September 1<sup>st</sup> of the current school year)**? \_\_\_\_\_
- b) If you have used, on average, more than six (6) sick days per year, please explain below.
- c) If you have worked for more than one (1) school board, provide dates and state whether or not accumulated sick days were transferred.

6 In Ontario, I have been teaching/employed in an educational capacity or by a federation for \_\_\_\_\_ year(s) **(up to and including September 1<sup>st</sup> of the current school year).**

- 7 a) Since the time you have been teaching, have you made regular contributions to an approved pension plan (e.g. Ontario Teachers' Pension Plan)?    Yes    No
- b) If you answered "Yes", how many years of **actual service credit** do you have in this plan? \_\_\_\_\_
- c) If your pension plan is not Ontario Teachers' Pension Plan, please indicate the name in the space provided below.

**3 POLICY INFORMATION PEEL PLAN**

1) Please check the level of coverage you wish to apply for within the Peel Plan:     2500     3000     3500     4000     4500

**4 CURRENT COVERAGE INFORMATION**

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

Company Name	Issue Date (mm/dd/yy)	Disability Amounts	Benefit Period

**5 OTHER INFORMATION RELATIVE TO THE APPLICATION FOR INSURANCE**

	Yes	No
1) Have you any other applications for life, disability or critical illness insurance policies 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) 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 details below.		
5) 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?		
6) 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 _____		
7) Have you ever been convicted of a criminal offence, or are criminal charges currently pending against you? If "Yes", provide dates and describe the nature of conditions and charges in the space provided below.		
8) 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		
9) If you answered "Yes" to questions 1) through 7) of this section, please provide further details in the space provided.		

## 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?
d) Dates of last visit:		e) Reason consulted and outcome, including medications:	
f) If no visits in the last six (6) months, indicate date (dd/mm/yy) of last visit:		g) Reason consulted and outcome, including medications:	
2a) Height (ft/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	
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. Note, additional space is available on page 5 under *Additional Information/Clarification*.

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, under *Additional Information/Clarification*, indicating conditions, dates, duration, results, names and addresses of doctors, clinics, etc. Number the answers to correspond to the questions.

	Yes	No
<b>FEMALES ONLY</b>		
4) a) Are you pregnant or suspect you might be? If "Yes", provide 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, counselled, or had any known indication of, or been told you had:

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?		
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?		

<b>Have you ever had, been tested, treated, counselled, or had any known indication of, or been told you had:</b>	<b>Yes</b>	<b>No</b>
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", please indicate number of drinks per week: _____ / 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 below in section 7.		



## 9 WHO WILL BE YOUR BENEFICIARY

If your beneficiary is a minor, state the name of a trustee, e.g. "John Doe, in trust for Mary Smith". **Unless indicated in writing, your beneficiary is your estate.**

Select a Beneficiary as Appropriate	Full Name of Beneficiary	Relationship to the Insured	Date of Birth (dd/mm/yy)
<input type="radio"/> Primary <input type="radio"/> Contingent <input type="radio"/> Trustee (if applicable)			
<input type="radio"/> Primary <input type="radio"/> Contingent <input type="radio"/> Trustee (if applicable)			
<input type="radio"/> Primary <input type="radio"/> Contingent <input type="radio"/> Trustee (if applicable)			
<input type="radio"/> Primary <input type="radio"/> Contingent <input type="radio"/> Trustee (if applicable)			

### Definitions

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

**Contingent:** 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:** should be named for all minor children listed above.

## 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, the Medical Information Bureau, the Motor Vehicle Division in any province requiring such authorization 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 out 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 if offered by my employer. If any payroll deductions cease for any reason, I must arrange for an alternate form of payment. As a convenience to me, the proposed insured or policyowner (if applicable), if I choose payment by electronic funds transfer, I hereby authorize and direct Teachers Life and any financial institution it uses, to initiate electronic funds transfers, or other forms of pre-authorized cheque withdrawals (debits) from my account at the financial institution listed on the "VOID" cheque enclosed with this application. This authority is to remain in full force and effect until Teachers Life has received notification from me of its termination in such time and in such manner as to afford Teachers Life reasonable opportunity to act on it. Any changes to this banking information must be provided to Teachers Life fifteen (15) days prior to the withdrawal date.

### Acknowledgment

I acknowledge that I have read and understood the Medical Information Bureau Notice and the 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 my insurability 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 (2) 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 and understood this section of this application. I have also read and answered all of the questions carefully.

## 11 SIGNATURE

Signature of Proposed Insured \_\_\_\_\_ Date (dd/mm/yy) \_\_\_\_\_

## 12 DECLARATION OF WITNESS

A witness is a principal, vice-principal or person at your location of employment involved in education.

The applicant is at present actively and regularly at work and appears to be in good health.

Name of Witness \_\_\_\_\_ Position \_\_\_\_\_

Signature of Witness \_\_\_\_\_ Date (dd/mm/yy) \_\_\_\_\_

Please send completed form to:

Teachers Life Insurance Society (Fraternal)™

916 The East Mall, Suite C, Toronto, ON, M9B 6K1

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