APPLICATION FOR INDIVIDUAL TERM LIFE INSURANCE PLANS

Contact us for assistance with completing this application at 1-855-894-2782.
Please print clearly in black or blue ink. Thank you.

SECTION 1 Applicant Information

❍ 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:____

Group:____

Occupation:____

Gross Annual Salary: $__________________________________

Income from other Sources: $____________________________

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

Country of Birth:_______________________________________

❍ Single ❍ Married ❍ Common Law

❍ Non-smoker ❍ Smoker

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:____

Group:____

Occupation:____

Gross Annual Salary: $__________________________________

Income from other Sources: $____________________________

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

Country of Birth:_______________________________________

❍ Single ❍ Married ❍ Common Law

❍ Non-smoker ❍ Smoker

SECTION 2 Choose Your Product & Amount of Insurance Coverage (minimum coverage applies)

Applicant

❍ Teachers Life Term 20
($50,000 minimum - $1 million maximum)

❍ Teachers Life PermaTerm 100
($10,000 minimum - $500,000 maximum)

Amount

❍ $10,000 (PT100 only)
❍ $50,000
❍ $100,000
❍ $200,000
❍ Other______________

Spouse/Family Member (if applying for coverage)

❍ Teachers Life Term 20
($50,000 minimum - $1 million maximum)

❍ Teachers Life PermaTerm 100
($10,000 minimum - $500,000 maximum)

Amount

❍ $10,000 (PT100 only)
❍ $50,000
❍ $100,000
❍ $200,000
❍ Other______________

SECTION 3 Method of Payment (Choose one of the following – for coverage to begin, you must indicate a payment method.)

❍ Monthly Payment by Pre-Authorized Debit (PAD)
To avoid delays, please include the PAD form and VOID cheque with your application.

OR

❍ Annual Payment
Full payment is required once underwriting is completed.

❍ Monthly by Credit Card

Type: ❍ Visa ❍ Mastercard ❍ Amex

Credit Card #:

Expiry Date: ____________
MM/YYYY

SECTION 4 Beneficiary (You must pick one of the following options).

❍ OPTION A: NAMED BENEFICIARY

The person(s) or organization(s), you as the policy owner name to receive the benefit or money, tax free from your life insurance policy.

NOTE: If you have more than 3 Named Beneficiaries provide the information on an additional sheet of paper.

❍ OPTION B: ESTATE

The benefit of your insurance policy becomes a part of your assets at the time of death and may be used to pay outstanding debts, which could include taxes, loans or other obligations, plus any costs associated with settling the estate (i.e. probate and legal fees). After this is complete, any remaining funds may be distributed according to the terms of your will.

❍ APPLICANT ❍ SPOUSE / FAMILY MEMBER

Applicant

Beneficiary Name:____________________

Relationship:____________________

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

Status: ❍ primary ❍ contingent ❍ trustee (if applicable)

Beneficiary Name:____________________

Relationship:____________________

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

Status: ❍ primary ❍ contingent ❍ trustee (if applicable)

Beneficiary Name:____________________

Relationship:____________________

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

Status: ❍ primary ❍ contingent ❍ trustee (if applicable)

Spouse / Family Member (if applying for coverage)

Beneficiary Name:____________________

Relationship:____________________

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

Status: ❍ primary ❍ contingent ❍ trustee (if applicable)

Beneficiary Name:____________________

Relationship:____________________

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

Status: ❍ primary ❍ contingent ❍ trustee (if applicable)

Beneficiary Name:____________________

Relationship:____________________

Date of Birth:____________________

Status: ❍ primary ❍ contingent ❍ trustee (if applicable)

SECTION 5 Information About Proposed Insured

	Applicant	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, hang-gliding, mountaineering, bungee-jumping, automotive sports, etc.)	❍ Yes ❍ No	❍ Yes ❍ No
3. During the last three (3) years, have you:		
a) had your driver's license suspended or have you 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 you 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 America 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 provided 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#:___Name:________________Details:____________________

Question#:___Name:________________Details:____________________

Question#:___Name:________________Details:____________________

Question#:___Name:________________Details:____________________

Note: Teachers Life may request a medical examination, urinalysis and/or test such as general blood profile which will be made at no expense to the applicant.

SECTION 6 Health Information and Questions (please answer ALL questions)

APPLICANT

Physician's Name:____________________

Tel: (_____)____________________

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

Reason for Last Visit:____________________

Results of Last Visit:____________________

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

Have you ever had or been told that you had suffered, or had any known indication, or been treated for any of the following diseases, afflictions or disorders, or have you ever felt any symptoms?	APPLICANT	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 medications, or any natural health products, counseling 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 AIDS test), or any test results indicating possible exposure to the AIDS virus, or any generalized enlargement of the lymph nodes or any unusual infections 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 heart or circulatory disorder, coronary artery disease or stroke, chest pains, high blood pressure, respiratory disorder (except for colds and flu), cancer, tumor or 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 yet consulted a doctor or been advised to undergo any tests which 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 cigarettes, cigars, cigarillos, pipes, chewing tobacco, marijuana, hashish, snuff or any other nicotine based product, including gum and patch?	❍ Yes ❍ No	❍ Yes ❍ No

Please provided details belowto 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 a medical examination, urinalysis and/or test such as a general blood profile which will be made at no expense to the applicant.

SECTION 7 Insurance Replacement Information

APPLCANT

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 to replace either a spousal or third party plan, the owner of the existing policy must consent to the replacement. A replacement form will be issued by Teachers Life.

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:__________

Note: If "Yes", Teachers Life may decline an application which indicates that replacement is intended.

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 to replace either a spousal or third party plan, the owner of the existing policy must consent to the replacement. A replacement form will be issued by Teachers Life.

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:__________

Note: If "Yes", Teachers Life may decline an application which indicates that replacement is intended.

SECTION 8 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 but not yet 65 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 applica tion 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)

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 related facility, insurance company, the MIB, the plan sponsor TW, 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 informa tion 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 with TW for member service purposes.

Payment Authorization If PAD:

Payment Authorization - I/we authorize Teachers Life Insurance Society (Fraternal) to withdraw monthly premiums from my/our bank account for insurance premiums due on or after the date accept this authorization. I/We authorize Teachers Life Insurance Society (Fraternal) to withdraw premiums on or about the first Thursday following the approval of my application and monthly on that date or the next business day thereafter. Withdrawals from my/our account may be for variable amounts and may change in accordance with the insurance contract and as required to administer the policy.

I/We agree to waive the 10 calendar days pre-notification requirements of the Canadian Payments Association of the amount(s) and due date(s) debited from my/our account and at any time there is a change in the amount(s) or payment date(s) of those debits. If my/our bank or financial institution does not honour an automatic monthly withdrawal the first time it is presented for payment, Teachers Life Insurance Society (Fraternal) may attempt to withdraw that payment again within 30 days. Teachers Life Insurance Society (Fraternal) reserves the right to ask me/us for an alternate method of payment if my/our payment is not honoured. All one-time or automatic withdrawals from my/our bank account will be treated as personal withdrawals as defined by the Canadian Payments Association in Rule H-1. I/We may cancel this agreement at any time upon providing written notice to Teachers Life. I/we understand that cancelling this PAD agreement does not terminate the insurance policy but could result in a loss of coverage if another form of payment is not received by Teachers Life Insurance Society (Fraternal). Any refund of premium paid pursuant to this authorization shall be made to the bank account on file. You may obtain a sample cancellation form by contacting your financial institution or through www.cdnpay.ca. If you have any questions about withdrawals from your bank account, contact us at insurning@teacherslife.com or write to us at Teachers Life, 916 The East Mall, Suite C, Toronto, Ontario, M9B 6K1. You have certain recourse rights if any debit does not comply with this agreement. As an example, you have the right to receive reimbursement for any PAD withdrawal that is not authorized or is inconsistent with this PAD agreement. To obtain a form for a Reimbursement Claim, or for more information on your recourse rights, contact your financial institution or visit www.cdnpay.ca. The parties have expressly requested that this Agreement and any related appendices or documents be drafted in the English language.

Name of Account Holder (if different from applicant)

____

(first, middle initial, surname - Please print)

If Credit Card: Payment Authorization - I/we hereby authorize Teachers Life Insurance Society (Fraternal) to make a withdrawal from my/our account on or about the first business day my policy is approved. Thereafter monthly withdrawals will occur on the same day each month from the policy effective date. If annual payment is selected, the annual withdrawal will take place the same time each year to the credit card provided. This Authorization may be terminated by either Teachers Life Insurance Society (Fraternal) or by me through written notice. The parties have expressly requested that this Agreement and any related appendices or documents be drafted in the English language.

This program is underwritten by Teachers Life Insurance Society (Fraternal)™, 916 The East Mall, Suite C, Toronto, ON M9B 6K1. Tel: 416 620-1140. Fax: 416 620-6993. Toll Free: 10800 668-4229. teacherslife.com

X____

APPLICANT'S SIGNATURE (Policy owner)

____

DATE

X____

SPOUSE/FAMILY MEMBER SIGNATURE (Policy owner) only applcable if applying for coverage

____

DATE

Before mailing this application be sure you have ...

- ❍ indicated your coverage selection
- ❍ indicated your preferred payment method
- ❍ "VOID" cheque, if applicable

Return your completed application to:

Mail: Orbit Insurance Services, 17704 - 103 Avenue, Suite 100, Edmonton AB, T5S 1J9
Fax: 1-866-373-1119