STF | OPTIONAL LIFE INSURANCE

INSURANCE APPLICATION

INITIAL ENROLMENT IN PORTAPLAN

If you are initially enrolling in Portaplan, please complete:

- the Insurance Application (required)
- the Beneficiary Designation (required)
- Pre-Authorized Debit (PAD) Agreement (optional)

INCREASING COVERAGE IN PORTAPLAN

If you are increasing your coverage in Portaplan, please complete:

- the Insurance Application (required)
- the Beneficiary Designation (optional)
- Pre-Authorized Debit (PAD) Agreement (optional)

BENEFICIARY DESIGNATION

The Beneficiary Designation is only required if you are changing the beneficiary presently on file. When recorded, a revised Certificate of Insurance will be mailed to you.

Note: This form changes the beneficiary designation(s) under Portaplan only. If you have other benefits or coverage, you must contact those plans directly.

PRE-AUTHORIZED DEBIT (PAD) AGREEMENT

The Pre-Authorized Debit (PAD) Agreement is only required if you wish to enrol in Pre-Authorized Debit or change the account from which your payment is being made.

QUESTIONS?

For more information on any aspect of Portaplan:

- Visit the Benefits section of the Saskatchewan Teachers' Federation website at: www.stf.sk.ca > Pension & Benefits > Teacher Benefits > Life Insurance > Optional Life Insurance
- Email portaplan@stf.sk.ca
- Call Portaplan at 1-800-667-7762 or 306-373-1660 in Saskatoon

Completion of the entire application is required. Please print clearly in dark ink and be sure to date and sign the application before mailing or emailing it to:

Portaplan
Saskatchewan Teachers' Federation
2317 Arlington Avenue
Saskatoon SK S7J 2H8

portaplan@stf.sk.ca

STF-00125 / 20241028 / 7080-50

Portaplan is underwritten by
Manulife Financial

STF OPTIONAL LIFE INSURANCE

INSURANCE APPLICATION

Office Use Only

Plan #G0021087 **Account/Division** #600 **Portaplan Policy #** ❑ New ❑ Existing ❑ Reinstatement

Effective Date (Day/Month/Year, e.g., 31 JAN 2000)

Date Submitted to Manulife (Day/Month/Year, e.g., 31 JAN 2000)

Subject to Medical Underwriting:
Term Life ❑ Yes ❑ No **Dependant Life** ❑ Yes ❑ No

Term Life Units **Dependant Life Units** 1 **Accident** ☑ No

Verification of Eligibility

Required for all applications.

Eligible Member's Name | Teacher's Certificate # | Portaplan Policy Number (if applicable)

Eligibility by virtue of:

- ☐ STF Member
  Is this your ☐ First Year of Teaching ☐ Second Year of Teaching
- ☐ Full-time Education Student at the U of R/U of S *(attach verification of registration)*
- ☐ LEADS Member
- ☐ Secretary/Treasurer for a Saskatchewan school division
- ☐ Employee of STF or TCU Financial Group
- ☐ Spouse or Eligible Child of the above mentioned person
- ☐ Member of STF Portaplan
- ☐ Superannuated Teacher

Applicant Statement

Each person applying for a policy in their own name must complete and sign a separate form.

Last Name | First Name | Initial | Preferred Name

The applicant is the: ☐ Eligible member ☐ Eligible member's spouse ☐ Eligible member's child (over 16 but less than 26)

Home Mailing Address | City/Town | Province | Postal Code

Email Address | Home Phone ( )

Employer | Occupation/Position | Work Phone ( )

Billing Address ☐ Same as above or

Height ○ ft/in ○ m/cm | Weight ○ lbs ○ kg | Gender ○ Male ○ Female | Date of Birth (Day/Month/Year, e.g., 31 JAN 2000)

Have you lost or gained more than 10 lbs/4.5 kg during the last 12 months? ○ Yes ○ No

If "Yes": What was the amount of weight change? ○ lbs ○ kg Was this a ○ gain or ○ loss? Reason:

Have you smoked (cigarettes, cigars, pipe, etc.) or used tobacco in any other form within the last 12 months? ○ Yes ○ No

Personal Physician Information

Last Name | First Name | Initial | Phone Number ( )

Mailing Address | City/Town | Province | Postal Code

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Coverage Applying For – Use the premium rates set at July 1st.

Only indicate units applying for.

Term Life Insurance (30 units available) Current rates can be found on the STF website at www.stf.sk.ca > Pension & Benefits > Teacher Benefits > Life Insurance > Optional Life Insurance > Term Life Insurance	Number of Units		**X** monthly premium per unit	$	=	$ 0.00
Accident Insurance (30 units available)	Number of Units		**X** monthly premium per unit	$ 0.45	=	$ 0.00
Dependant Insurance* (only one unit available for spouse and dependent children) The monthly premium is only $2.25 no matter how many dependants you have.	One available Unit		**X** monthly premium per unit	$ 2.25	=	$ 0.00
			Total monthly premium		=	$ 0

Dependant Insurance

To be completed when applying for dependant insurance (spouse and dependent children).

Last Name of Eligible Dependant | First Name | Initial | Date of Birth (Day/Month/Year, e.g., 31 JAN 2000)

Height (ft/in, m/cm) | Weight (lbs, kg) | Gender (Male, Female) | Relationship to Applicant (Spouse, Child)

Last Name of Eligible Dependant | First Name | Initial | Date of Birth (Day/Month/Year, e.g., 31 JAN 2000)

Height (ft/in, m/cm) | Weight (lbs, kg) | Gender (Male, Female) | Relationship to Applicant (Spouse, Child)

Last Name of Eligible Dependant | First Name | Initial | Date of (Day/Month/Year, e.g., 31 JAN 2000)

Height (ft/in, m/cm) | Weight (lbs, kg) | Gender (Male, Female) | Relationship to Applicant (Spouse, Child)

Last Name of Eligible Dependant | First Name | Initial | Date of Birth (Day/Month/Year, e.g., 31 JAN 2000)

Height (ft/in, m/cm) | Weight (lbs, kg) | Gender (Male, Female) | Relationship to Applicant (Spouse, Child)

Last Name of Eligible Dependant | First Name | Initial | Date of Birth (Day/Month/Year, e.g., 31 JAN 2000)

Height (ft/in, m/cm) | Weight (lbs, kg) | Gender (Male, Female) | Relationship to Applicant (Spouse, Child)

Date of Marriage (Day/Month/Year, e.g., 31 JAN 2000) OR Date Cohabitation Began (Day/Month/Year, e.g., 31 JAN 2000)

Has your spouse smoked (cigarettes, cigars, pipe, etc.) or used tobacco in any other form within the last 12 months? ☐ Yes ☐ No

Personal Physician Information (for dependants)

Last Name | First Name | Initial | Phone Number ( )

Mailing Address | City/Town | Province | Postal Code

Statement of Insurability

Required for Applicant's Term Insurance and Dependant Insurance

Please provide details below if you have answered "YES" to any questions in this section.

Yes	No		
○	○	1.	Do you or any of your dependants who are to be insured currently participate in any hazardous sport activity, such as SCUBA diving, piloting aircraft, auto racing, etc.? Please specify the name of the individual and which activity.
○	○	2.	Have you or any of your eligible dependants who are to be insured:
○	○	(a)	had any condition which might require medical consultation, hospitalization or future surgical or psychiatric treatment?
○	○	(b)	had any family history or any inherited or familial disease (eg. Huntington's Chorea, diabetes, heart or kidney disease)?
○	○	(c)	ever had an application for life or health insurance declined, postponed or modified in any way?
○	○	(d)	currently receiving any treatment?
○	○	3.	Have you or any of your eligible dependants who are to be insured ever consulted a physician, ever been treated for or had any known indication of:
○	○	(a)	chest pain, blood vessel disease, heart disorder or heart attack?
○	○	(b)	high blood pressure, stroke?
○	○	(c)	allergies or skin disorders, including growths, cysts or tumours?
○	○	(d)	glandular disorders, including thyroid disorders and diabetes?
○	○	(e)	epilepsy, nervous or mental illness, or an emotional condition such as anxiety or depression?
○	○	(f)	excessive use of alcohol or drugs?
○	○	(g)	lung disorders?
○	○	(h)	bowel disorders, stomach or liver disorders?
○	○	(i)	cancer?
○	○	(j)	disorder of the kidney, urine or genital organs?
○	○	(k)	arthritis or rheumatism?
○	○	(l)	disorders of the muscles or bones including the back, spine or joints?
○	○	(m)	immune deficiency disorder including AIDS or AIDS-related complex (ARC), or any generalized enlargement of the lymph glands, or any test results indicating possible exposure to the AIDS (eg HTLV-lll, LAV) virus?
○	○	(n)	any physical impairments, deformities, amputations or illness not covered above?

Question #	Name of Person (First & Middle)	Relationship	Details or Name of Condition	Date & Duration	Treatment and Results	Name & Address of Doctors & Hospitals

Authorization and Acknowledgement

To be read and signed by the Applicant (also to be signed by spouse if applying for dependant insurance)

I hereby apply to Manulife Financial for insurance under Portaplan Group Policy #G0021087-600 issued to the Saskatchewan Teachers' Federation. I understand and agree that this insurance will become effective on the date my application and premiums are received by the STF, subject to approval by Manulife Financial.

It is understood and agreed that any statement in this application will be incontestable, unless fraudulent, after any resulting policy has been in force for two years during my lifetime.

For this insurance, I hereby authorize any organization, institution or person, including any medical practitioner or medically related facility, or insurance company, that has any records or knowledge of me or my health to give the STF, Manulife Financial or its reinsurers any such information. A photocopy of this authorization shall be as valid as the original. I acknowledge receipt of a notice on exchange of information.

I hereby consent to the procurement or preparation of a consumer report containing personal information on me and/or my dependants.

I confirm that the foregoing information is true, complete and accurate as of this date and shall form part of the application for insurance. Only for the purposes of payment of claims, underwriting, administration or marketing of Portaplan do I consent to the STF obtaining, retaining, disclosing, exchanging and using any personal information about me or my dependants, at any time from, to or with others, including STF's affiliates, service suppliers, successors, assigns and other persons.

Applicant's Signature X _____ Date _____
(Day/Month/Year, e.g., 31 JAN 2000)

Spouse's Signature* X _____ Date _____
(Day/Month/Year, e.g., 31 JAN 2000)
(*If applying for dependant insurance)

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