OVERAGE DEPENDANT VERIFICATION FORM

Please print clearly in INK. Once you have completed this form and attached any additional documentation required, you must mail the original form to OTIP Benefits Services, address found at the bottom of this form. If you have any questions, please call OTIP Benefits Services at 1.866.783.6847.

Name of Policyholder	Policy	Certificate No.
Peel Elementary Teachers' Local	84545	

	First Name	Surname	Initial
Employee			

	First Name	Surname	Initial
Dependant			
	Date of Birth (DD/MM/YYYY)		

PLEASE COMPLETE THIS SECTION IN FULL

1. Is your dependant attending school?	☐ Yes	☐ No
If NO, proceed to Question 4: If YES, provide the name of the school and the address:		
Full name of School	Full Address	
2. Is your dependant attending school as a:	☐ Full-Time Student	☐ Part-Time Student
3. Please indicate when his/her schooling commences and is scheduled for completion:		
Commencement Date (DD/MM/YYYY)	Completion Date (DD/MM/YYYY)	
4. a) Is your dependant currently employed:	☐ Yes	☐ No
b) Is your dependant working:	☐ Full-Time	☐ Part-Time
c) Provide information	Date of Hire (DD/MM/YYYY)	# of Hours Working Per Week
5. Is your dependant disabled?	☐ Yes	☐ No
If yes, please provide details:		
Please provide name and address of dependant's primary care physician:		
Primary Care Physicians Full Name:	Full Address Telephone No. ( )	

MEMBER'S SIGNATURE	DATE (DD/MM/YYYY)

FORM NO. 2011/1003PETL

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