OTIP RAEO

ONTARIO TEACHERS INSURANCE PLAN
125 Northfield Drive West
P. O. Box 218
Waterloo ON N2J 3Z9
(519) 888-9683 | 1-800-267-6847

GROUP BENEFITS APPLICATION FORM

BASIC PERSONAL DATA (MUST BE COMPLETED)

NAME _____ (LAST) _____ (FIRST) _____ (MIDDLE)

GENDER F ☐ M ☐

ADDRESS _____

CITY _____

POSTAL CODE _____ PHONE _____ – _____

EMPLOYEE NO. _____

BOARD _____

POLICY NO. _____

YEARLY GROSS SALARY
(INCLUDING ALLOWANCES, EXCLUDING OVERTIME) $ _____ .00

E-MAIL ADDRESS: _____

EMPLOYEE TYPE (CHECK ONE)

INDICATE MEMBERSHIP OF:

OECTA	ELEM ☐	ADMINISTRATION	☐
	SEC ☐	CLERICAL	☐
ETFO	☐	TRADESPERSON	☐
OSSTF TEACHER	☐	OTHER _____	

DATE OF BIRTH _____ (MONTH) _____ (DAY) _____ (YEAR)

DATE OF HIRE WITH BOARD _____ (MONTH) _____ (DAY) _____ (YEAR)

ELIGIBLE FOR BENEFIT _____ (MONTH) _____ (DAY) _____ (YEAR)

EFFECTIVE DATE _____ (MONTH) _____ (DAY) _____ (YEAR)

A LONG TERM DISABILITY INCOME PROTECTION INSURANCE

YES, I WISH TO HAVE THE COVERAGE ☐

B DEPENDENT LIFE ☐ YES

C BASIC LIFE INSURANCE (SEE DETAILS FOR YOUR GROUP)

BASE AMOUNT $ _____ .00 AD&D BASE AMOUNT $ _____ .00

OPTIONAL/SPOUSAL LIFE INSURANCE

IF YOU ARE INTERESTED IN APPLYING FOR OPTIONAL/SPOUSAL LIFE INSURANCE, PLEASE SEE YOUR PLAN ADMINISTRATOR FOR THE NECESSARY FORMS.

D DESIGNATION OF BENEFICIARY (If more space is required, please complete a second form and attach.)

	BENEFICIARY'S LAST NAME	FIRST NAME	INITIAL	RELATIONSHIP	PERCENTAGE
1.					
2.					

Under the laws of Quebec, any designation of a spouse as a beneficiary is irrevocable unless stipulated to be revocable.
I hereby declare and stipulate that the beneficiary designation(s) made on this form is (are) revocable.

Note: If you designate a minor child as the beneficiary of your insurance proceeds, these proceeds will be paid into court, unless a trustee is appointed to receive such benefits on behalf of such child. Trustee Appointment (you may wish to consult a lawyer before appointing a Trustee):

I hereby appoint my beneficiary. _____ (Spouse, Brother etc.) , _____ (Name) as the Trustee to receive the Benefits on behalf of my minor

Witness _____ Plan Member Signature _____ Date (mm/dd/yy) _____

I hereby designate the above beneficiary to receive any amount due on my death while insured under this Group Policy.

Please ensure you also sign and date the bottom of this form prior to submission.

CONTINGENT BENEFICIARY (alternate beneficiary, should the choice beneficiary predecease you)

FIRST NAME MIDDLE INITIAL LAST NAME RELATIONSHIP

E EXTENDED HEALTH COVERAGE

YES, I WISH THE COVERAGE ☐

SINGLE ☐ FAMILY ☐

NO, I AM COVERED BY MY SPOUSE'S PLAN ☐

DENTAL COVERAGE

YES, I WISH THE COVERAGE ☐

SINGLE ☐ FAMILY ☐

NO, I AM COVERED BY MY SPOUSE'S PLAN ☐

BIRTH DATE MO.	DAY	YR.	INDIVIDUAL REGISTRATION FIRST OR GIVEN NAME	INITIAL	GENDER M – MALE F – FEMALE
			EMPLOYEE'S		
			SPOUSE		
			CHILDREN		

Does your spouse have any dental or supplementary health insurance coverage? Yes ☐ No ☐ Policy No. _____

Name of spouse's insurance carrier _____ Spouse's identification no. _____

Please Indicate with an "✓" in the appropriate box, each benefit covered under your spouse's plan.

☐ Semi Private ☐ Prescription Drugs ☐ Vision ☐ Dental ☐ Extended Health Care

F WAIVER OF BENEFITS (To be completed and signed by Plan Member if waiving benefits)

ONLY THOSE BENEFITS WHICH ARE NOT A CONDITION OF EMPLOYMENT CAN BE WAIVED

I have been given the opportunity to apply for coverage, but do not wish to participate. I understand that if I wish to request coverage at a later date, I will be required to furnish, at my own expense, (and if applicable, for my eligible dependent(s)) evidence of insurability.

I wish to waive the following benefit(s):

☐ LTD ☐ EXTENDED HEALTH CARE ☐ DENTAL
☐ BASIC LIFE ☐ AD&D ☐ Dependent Group Life

Plan Member's Signature _____ Date (M/D/Y) _____

I hereby make application for benefits as outlined above and certify that the information disclosed herein is accurate and complete and consent to such information being used for the purpose of understanding my needs, evaluating my eligibility to the plan, providing me with ongoing services, protecting us both against error and fraud and complying with various legal requirements.

I further understand that, unless this application is completed and submitted within 31 days of my becoming eligible to secure benefits under the plan, my application will be subject to the rules of the plan as follows: a late applicant will be required to submit proof of insurability at his/her own expense (attach if applicable); and a new employee shall not be considered a late applicant if the application is made within 31 days of becoming eligible.

I authorize the Board to make payroll deductions as applicable and authorize the use of my employee number for the administration of my benefits applied for under this application. I further authorize the plan administrator, OTIP, to act on my behalf in dealing with the insurance carrier of the existing policy or any successor policy, concerning my application for group insurance, changes in insurance, notification of insured information and any other administrative matters. I understand that this authorization terminates on the earlier of the change in my employment status with the Group/Board, which affects my eligibility under the policy, or a termination of the insurance between the Group/Board and the plan administrator, OTIP.

Date _____ (mm/dd/yyyy) Signature _____

Name (please print) _____