OTIP RAEO

Peel Elementary Teachers' Local

# Instructions for completing the Extended Health and Dental Coverage Change Form

***Please read carefully***

**General** - Print clearly in blue or black ink. Please send the original, completed form with required documentation attached to OTIP benefits services (see form for address). If you have any questions, please call OTIP benefits services at 1-866-783-6847.

Benefits are fully funded for full-time employees (1.0 FTE) and are partially funded for part-time employees (less than 1.0 FTE).

If you are taking a **leave of absence** and wish to waive any or all of your benefits, please contact OTIP benefits services for the applicable forms.

**Name and address changes** – Please update your name and address on the Peel School Board's VISTA self serve system. To access VISTA, go to www.peelschools.org/login and sign in. If you have any questions about how to update your address, please refer to the VISTA Self Service Overview. The video overview demonstrates how to change your name and address.

**Life events and timelines** - When you experience a life event, you may be able to change or cancel certain benefits, based on other eligibility requirements. A life event is considered the birth or adoption of a child, a change in martial status, change in eligibility for common-law status, the loss of spousal benefits, or an increase or decrease in your FTE status (e.g., 0.2 to 0.6 or 0.8 to 0.4), including becoming a 1.0 FTE.

**PLEASE NOTE:** In order to make changes to your benefits without having to provide medical evidence of insurability, OTIP benefits services must receive this completed form **within 31 days** of the date the life event occurred. If you submit this form more than 31 days after the event, your added or changed benefits will be subject to late entrant requirements (e.g., medical approval and associated costs, dental coverage restrictions for the first year).

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**You can use this Extended Health and Dental Coverage Change Form for the following:**

### *Benefits Change*

If you are a 1.0 FTE, benefits for your dependants will be fully funded, provided sections **A, B and D** of this form are completed and the form is signed and submitted to OTIP benefits services **within 31 days** of a life event.

### *Cancellation of Benefits*

If you are less than 1.0 FTE, you can decline health and/or dental benefit coverage after a life event occurs. If you are 1.0 FTE, you must maintain extended health and dental benefits for yourself; however, you can waive those benefits for your dependants after a life event occurs. To cancel benefits, complete sections **A and C** of this form, sign it, and send it to OTIP benefits services **within 31 days** of a life event. Cancellation of benefits will take effect on the last day of the month following the date this form is signed.

If you cancel your benefits, one of the following changes must occur before your coverage can be changed or reinstated:

1. An increase or decrease in your FTE status (e.g., 0.2 to 0.6 or 0.8 to 0.4), including becoming a 1.0 FTE.
2. A life event (e.g., change in marital status, birth/adoption of a child, loss of spousal benefits).

OTIP RAEO®

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# Extended Health and Dental Coverage Change Form

Peel Elementary Teachers' Local

**Please print clearly in INK.** Once you have completed this form and attached any additional required documentation, please mail the original form to OTIP Benefits Services. If you have any questions, please call OTIP Benefits Services at 1-866-783-6847.

## Basic Personal Information (Must be completed)

Please contact the Peel District School Board for all name and address changes.

| Name (Last, First and Middle Initial) | Gender ☐ Male ☐ Female |
|---|---|
| Address (Number, Street and Apt.) | |
| City / Prov. | Postal Code |
| Home Telephone Number ( ) | Work Telephone Number ( ) |
| E-mail Address | Employee Number |

| Policy Number **84545** | Certificate Number (found on your benefits card) | Date of Birth *(mm/dd/yyyy)* | Date of Hire *(mm/dd/yyyy)* |
|---|---|---|---|
| | | | |

## Reason for Change (Must be completed)

Reason for Change: _____

(e.g., birth or adoption of a child, change in marital status, eligibility for common-law status, change in FTE status, etc.)

Date Change Occurred: *(mm/dd/yyyy)* _____

Please note: for common-law status, indicate the date you started living together.

This form must be completed and signed within 31 days of the date the change occurred to prevent the member and his or her dependant(s) from being subject to late entrant requirements (e.g., medical approval and associated costs, decrease in coverage for the first year).

## Benefit(s) to Add

☐ Health care

☐ Dental care

## Benefit(s) to Change

Health care: ☐ Family to Single ☐ Single to Family

Dental care: ☐ Family to Single ☐ Single to Family

## Cancellation of Benefits

You can opt to decline health and/or dental benefit coverage if you are employed part-time (i.e., less than 1.0 FTE). If you are employed full-time (i.e., 1.0 FTE) you must maintain extended health and dental benefits for yourself; however, you can waive those benefits for your dependants.

Please indicate your current FTE status (e.g., 1.0, 0.5): _____

I understand the following group benefits are offered to me, but I decline to participate in:

Health care for: ☐ myself OR ☐ myself and my dependants OR ☐ my dependants only Effective Date: *(mm/dd/yyyy)* _____

Dental care for: ☐ myself OR ☐ myself and my dependants OR ☐ my dependants only Effective Date: *(mm/dd/yyyy)* _____

Cancellation of benefits take effect on the last day of the month following the date this form is signed.

IMPORTANT

If you refuse benefits at this time, one of the following changes must occur before your coverage can be changed or reinstated:

1. An increase or decrease in your FTE status (e.g., 0.2 to 0.6 or 0.8 to 0.4), including becoming a 1.0 FTE.
2. A life change (e.g., change in marital status, birth/adoption of a child, loss of spousal benefits).

## Dependant Information Change

### Spouse

| | **Spouse Information -** First and Last Name | Date of Birth *(mm/dd/yyyy)* | Gender M – Male F – Female |
|---|---|---|---|
| ☐ Add ☐ Delete | | | |

What group benefits does your spouse have through an employer?

| | | | | |
|---|---|---|---|---|
| Health Care: | ☐ Single | ☐ Family | ☐ Waived | ☐ None |
| Dental Care: | ☐ Single | ☐ Family | ☐ Waived | ☐ None |
| Vision Care: | ☐ Single | ☐ Family | ☐ Waived | ☐ None |

### Children

| | **Dependant Information -** First and Last Name | Date of Birth *(mm/dd/yyyy)* | Gender M – Male F – Female | Full-Time Student | | Disabled | |
|---|---|---|---|---|---|---|---|
| | | | | Yes | No | Yes | No |
| ☐ Add ☐ Delete | | | | | | | |
| ☐ Add ☐ Delete | | | | | | | |
| ☐ Add ☐ Delete | | | | | | | |
| ☐ Add ☐ Delete | | | | | | | |

**Special Note:**

If you checked Yes under Full-Time Student, and your dependant is between the ages of 19 and 25, please complete an overage dependant form. This form can be found online at www.otipservices.com.

If you checked Yes under Disabled, please contact an OTIP Benefits Services representative to review eligibility requirements.

## Agreement, Acknowledgement and Authorization

I hereby apply for benefits coverage outlined above and certify that the information disclosed herein is accurate and complete. I consent to such information being used for the purposes of understanding my needs, evaluating my eligibility for the plan, providing me with ongoing services, protecting us both against error and fraud and complying with various legal requirements. If applying for coverage for my spouse and/or dependants, I confirm that I am authorized to act on their behalf.

I authorize the Board to make payroll deductions, if applicable, and remit them to OTIP and/or OTIP to deduct premiums from my bank account and pre-authorization forms are completed. I authorize the use of my employee number for the administration of my benefits. 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 changes in insurance, notification of insured information and any other administrative matters. I understand 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.

**Member's Signature X**_____ **Date** *(mm/dd/yyyy)*_____