

RTIP Application Form

Benefits are administered by OTIP and underwritten by Manulife Financial.



Please return to:

125 Northfield Drive West, PO Box 218, Waterloo ON N2J 3Z9
 Phone: 1.800.267.6847 Fax: 1.800.346.3842

Please print using ballpoint pen.

SECTION A - GENERAL INFORMATION

Date of Birth (mm/dd/yy)	Applicant's Last Name	First Name	Middle Initial
Address		Apt.	
City/Town		Province	Postal Code
Home Telephone No. ()	Alternate Telephone No. ()	E-mail Address	

I prefer all correspondence in: English French

Indicate membership, prior to retirement:

Employee Type	Affiliation
Principal/ Vice Principal	<input type="checkbox"/> ADFO
	<input type="checkbox"/> CPCO
	<input type="checkbox"/> OPC
Teacher - Sec.	<input type="checkbox"/> AEFO
Teacher - Elem.	<input type="checkbox"/> ETFO
Clerical	<input type="checkbox"/> OECTA
Administration	<input type="checkbox"/> OSSTF
Trades	<input type="checkbox"/> University/College
Other _____	<input type="checkbox"/>

First Name & Initial (Provide last name if different from applicant)	Birth Date			Gender
	M	D	Y	
Applicant				
Spouse/Partner				
Dependant Child				
Dependant Child				
Dependant Child				

SECTION B - ELIGIBILITY

I wish to be covered under an RTIP plan starting: |M |D 01 |Y

Within the last 60 days:

I have been insured as an **active member** under a group health benefits plan.* Plan Termination Date: |M |D |Y

I have been insured as a **retired member** under a group health benefits plan.* Plan Termination Date: |M |D |Y

I have not been covered under a group health benefits plan in the last 60 days. Please call for an Application for Insurance and Evidence of Insurability form.

**Please complete the Policy information box below.*

Policy/Group No: _____ Identification/Certificate No: _____

Insurance Company Name: _____

SECTION C - COVERAGE SELECTION (Please choose RTIP Gold Elite, RTIP Plus, RTIP Gold or RTIP Basic)

RTIP GOLD ELITE

Single Couple Family

Extended Health Care \$ _____

(coverage for catastrophic expenses available until age 65, includes deluxe travel)
\$500 prescription drug max.

Hospital Accommodation \$ _____

Daily Max: \$75 \$100 Unlimited Semi-Private

Dental Coverage

Single Couple Family \$ _____

Total Premium (Add All Choices) \$ _____

RTIP GOLD

Single Couple Family

Extended Health Care \$ _____

(includes prescription drug coverage beyond age 65 and deluxe travel)

\$500 prescription drug max. \$850 prescription drug max.

Hospital Accommodation \$ _____

Daily Max: \$75 \$100 Unlimited Semi-Private

Dental Coverage*

Single Couple Family \$ _____

Total Premium (Add All Choices) \$ _____

*Dental coverage can be purchased separately. Please see page 17 for more information.

RTIP PLUS

Single Couple Family

Extended Health Care \$ _____

(includes prescription drug coverage beyond age 65, deluxe travel and unlimited semi-private hospital)
\$2,400 prescription drug max.

Dental Coverage

Single Couple Family \$ _____

Total Premium (Add All Choices) \$ _____

RTIP BASIC

Single Couple Family \$ _____

(includes prescription drug coverage beyond age 65, deluxe travel and \$100 per day hospital coverage)

Dental Coverage

Single Couple Family \$ _____

Total Premium (Add All Choices) \$ _____

To receive an annual income tax receipt indicating the amount of premiums you paid for your RTIP health and dental coverage, please check here.

From time to time, OTIP may send you information on our products, services and promotions. If you are not interested in receiving this information, please check here.

Authorization: I hereby apply for benefits as outlined above and certify that the information is accurate and complete. I consent to the collection, use and disclosure of my information for the purposes of understanding my needs, evaluating my eligibility to the plan, providing me with ongoing services, protecting us both from error and fraud, and complying with various legal requirements. I am authorized to consent to the collection, use and disclosure of information pertaining to my spouse/partner and/or dependant child, if applicable. I understand the information in this application will be shared with the Insurer underwriting the plan.

Signature X _____ Date _____

SECTION D - PAYMENT METHOD

METHOD A - Automatic monthly pension deduction for those in receipt of a pension from the Ontario Teachers' Pension Plan Board

I hereby apply for coverage under the Retired Teachers Insurance Plan with OTIP and direct the Ontario Teachers' Pension Plan Board to deduct and remit premiums from my pension for my contribution toward the cost of this benefit contract. I consent to the collection, use and disclosure of any information required to administer the program including personal information such as my Social Insurance Number. This authorization shall remain valid unless cancelled by me in writing.

Social Insurance # _____ Signature X _____ Date _____

METHOD B - Monthly pre-authorized payment plan I hereby authorize OTIP to withdraw premium payments from my account on or about the first day of each month. OTIP may terminate coverage should a withdrawal be refused for any reason and the financial institution shall in no way be held liable should such an event occur. This authorization shall remain valid unless cancelled by me in writing subject to providing notice of 5 days. I have certain recourse rights if any debit does not comply with agreement. For example, I have the right to receive reimbursement for any debit that is not authorized or is not consistent with this PAD agreement. To obtain more information about my recourse rights, I may contact my financial institution or visit www.cdnpay.ca.

Type of Account: Savings Chequing Current Other

A void cheque MUST accompany this application.

Is this a joint account requiring only one signature? Yes No

If both signatures are required, both persons must sign this form.

Signature of Account Holder(s): X _____ X _____ Date _____