

# RTIP Application Form

**Please return to:**

125 Northfield Drive West  
PO Box 218  
Waterloo ON N2J 3Z9

Phone: 1.800.267.6847  
Fax: 1.888.646.3842

Benefits are administered by OTIP and underwritten by Manulife Financial.

**Please print using ballpoint pen.**

## Section A | General Information

Date of Birth [mm/dd/yy]   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:			<input type="radio"/> English	<input type="radio"/> French	

First Name & Initial (Provide last name if different from applicant)	Date of Birth [mm/dd/yy]	Gender	Please complete if you have an eligible dependant student over the age of 21.		
Applicant	mm dd yy				
Spouse/Partner	mm dd yy		School Year Start	School Year End	Name of School
Dependant Child	mm dd yy				
Dependant Child	mm dd yy				
Dependant Child	mm dd yy				

## Section B | Eligibility

I wish to be covered under an RTIP plan starting: | mm | | 01 | | yy |

Within the last 60 days:

<input type="radio"/> I have been insured as an active member under a group health benefits plan.*	Plan Termination Date:   mm     dd     yy
<input type="radio"/> I have been insured as a retired member under a group health benefits plan.*	Plan Termination Date:   mm     dd     yy
<input type="radio"/> 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:	

<input type="radio"/> To receive an annual income tax receipt indicating the amount of premiums you paid for your RTIP health and dental coverage, please check here.	<input type="radio"/> 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.
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## Section C | Coverage Selection (Please pick one of the options below and fill in the appropriate information)

<b>RTIP Gold Elite</b>	<input type="radio"/> Single   <input type="radio"/> Couple   <input type="radio"/> Family	
Extended Health Care	(coverage for catastrophic expenses available until age 65, includes deluxe travel)	\$
Hospital Accommodation	Daily Max: <input type="radio"/> \$75   <input type="radio"/> \$100   <input type="radio"/> Unlimited Semi-Private	\$
Dental Coverage	<input type="radio"/> Single   <input type="radio"/> Couple   <input type="radio"/> Family	\$
<b>Total Premium (add all choices)</b>		\$
<b>RTIP Plus</b>	<input type="radio"/> Single   <input type="radio"/> Couple   <input type="radio"/> Family	
Extended Health Care	\$2,700 prescription drug max. (includes prescription drug coverage beyond age 65, deluxe travel and unlimited semi-private hospital)	\$
Dental Coverage	<input type="radio"/> Single   <input type="radio"/> Couple   <input type="radio"/> Family	\$
<b>Total Premium (add all choices)</b>		\$
<b>RTIP Gold</b>	<input type="radio"/> Single   <input type="radio"/> Couple   <input type="radio"/> Family	
Extended Health Care	<input type="radio"/> \$500 prescription drug max.   <input type="radio"/> \$1,000 prescription drug max. (includes prescription drug coverage beyond age 65 and deluxe travel)	\$
Hospital Accommodation	Daily Max: <input type="radio"/> \$75   <input type="radio"/> \$100   <input type="radio"/> Unlimited Semi-Private	\$
Dental Coverage	<input type="radio"/> Single   <input type="radio"/> Couple   <input type="radio"/> Family	\$
<b>Total Premium (add all choices)</b>		\$
<b>RTIP Basic</b>	<input type="radio"/> Single   <input type="radio"/> Couple   <input type="radio"/> Family	
Extended Health Care	<input type="radio"/> \$750 prescription drug max. (includes prescription drug coverage beyond age 65, deluxe travel and \$100 per day hospital coverage)	\$
Dental Coverage	<input type="radio"/> Single   <input type="radio"/> Couple   <input type="radio"/> Family	\$
<b>Total Premium (add all choices)</b>		\$
<b>RTIP Dental Coverage Only</b>	<input type="radio"/> Single   <input type="radio"/> Couple   <input type="radio"/> Family	\$

**Authorization:** I hereby apply for benefits coverage ("Coverage") and certify that the information provided is true and complete. I authorize OTIP and its Insurer to collect, use, maintain and disclose my personal information, including personal health information, ("Information") relevant to this application, for the purposes of evaluating my eligibility to the plan, benefits plan administration, providing me with ongoing services, protecting us both from error and fraud and complying with various legal requirements ("Purposes"). I am authorized to consent to the collection, use, maintenance and disclosure of Information pertaining to my Dependant(s) (spouse/child), if applicable, for the Purposes. I agree that the Information in this application will be shared with the Insurer and any Coverage shall not become effective until approved by the Insurer. I agree that my Coverage may be denied or terminated at any time as a result of any false, incomplete, or misleading information having been provided in support of this application.

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.

SIN # X \_\_\_\_\_ 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](http://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 \_\_\_\_\_