ARM Retiree Health Insurance Application Form

Please return to OTIP:
125 Northfield Drive West, PO Box 218, Waterloo ON N2J 3Z9
Phone: 1.800.267.6847 Fax: 1.888.646.3842

I prefer all correspondence in:
English ☐ French ☐

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)*	Applicant's Last Name	First Name	Middle Initial
Address		Apt.	
City/Town	Province		Postal Code
Home Telephone Number ( )	Alternate Telephone No. ( )	E-mail Address	

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

Membership prior to retirement:

Employee Type		***Affiliation***	
Teacher - Sec.	☐	OSSTF	☐
Teacher - Elem.	☐	AEFO	☐
Clerical	☐	ETFO	☐
Administration	☐	OECTA	☐
Trades	☐	University/ College	☐
Principal/ Vice Principal	☐	ADFO	☐
		CPCO	☐
		OPC	☐

Other ____________________

To receive an annual income tax receipt indicating the amount of premiums you paid for your ARM 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. ☐

SECTION B - ELIGIBILITY

I wish to be insured under an ARM health 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 insured 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 Number: ____________________ Identification/Certificate Number: ____________________

Insurance Company Name: ____________________

SECTION C - COVERAGE SELECTION *(Please choose ARM Prestige Elite, ARM Original, ARM Prestige, ARM Economy or ARM Dental only)*

ARM Prestige Elite Plan

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) $ ____________

ARM Original Plan

Single ☐ Couple ☐ Family ☐

Extended Health Care $ ____________
(includes prescription drug coverage beyond age 65, deluxe travel and unlimited semi-private hospital)

$2,500 prescription drug max.

Dental Coverage

Single ☐ Couple ☐ Family ☐ $ ____________

Total Premium (Add all choices) $ ____________

ARM Prestige Plan

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) $ ____________

ARM Economy Plan

Single ☐ Couple ☐ Family ☐

Extended Health Care $ ____________
(includes prescription drug coverage beyond age 65, deluxe travel and $100 per day hospital coverage)

$750 prescription drug max.

Dental Coverage

Single ☐ Couple ☐ Family ☐ $ ____________

Total Premium (Add all choices) $ ____________

ARM Dental Coverage Only

Single ☐ Couple ☐ Family ☐ $ ____________

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. I understand that upon becoming a member of the ARM health plan, I will also become a member of the ARM Organization (established by OSSTF).

I hereby authorize the Ontario Secondary School Teachers' Federation (OSSTF) to provide my personal information to ARM for the purposes of providing me with membership services and communicating with me about OSSTF and retirement matters.

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 an ARM health 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, 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 ☐

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

A void cheque MUST accompany this application.
If both signatures are required, both persons must sign this form.

Signature of Account Holder(s): X ____________ ***X*** ____________ ***Date*** ____________