OTIP RAEO®
Group Medical Underwriting
Manulife
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Overage Disabled Dependant Coverage

INSTRUCTIONS: (Please print all answers.)

1. Please consult your benefits booklet for coverage eligibility guidelines under your plan.
2. Please ensure **all sections** are completed, including the section to be completed by the physician.
   Sections 1, 2, 3 and 5 – To be completed by plan member
   Section 4 – To be completed by attending physician
3. Please send the completed and signed form to the above mailing address.
4. If required, retain a photocopy for your files.

SECTION 1: MEMBER BASIC PERSONAL INFORMATION

Plan Member Name (First, Middle Initial and Last)			
Address (Number, Street and Apt.)		City/Town	Province / Postal Code
Home Telephone Number	Work Telephone Number	Date of Birth *(mm/dd/yyyy)*	Gender ☐ Male ☐ Female
OTIP Identification Number	Health and Dental Policy Number	Email Address	
School Board	Plan Sponsor	Plan Number	Location (Class) (if applicable)

SECTION 2: DEPENDANT INFORMATION

Dependant Name (First, Middle Initial and Last)		Gender ☐ Male ☐ Female
Address (if different from Plan Member)	City/Town	Province / Postal Code
Date of Birth *(mm/dd/yyyy)*	Relationship to Plan Member	

SECTION 3: DISABLED DEPENDANT INFORMATION

1. Is the disabled dependant a resident of your home 365 days a year? ☐ Yes ☐ No
   If "No," please explain.

2. Has the disabled dependant ever been employed? ☐ Yes ☐ No
   If "Yes," please provide the most recent date of employment and description of type of employment.

Start Date (dd/mm/yyyy)	End Date (dd/mm/yyy)	Weekly Hours	Type of Employment

3. Has the disabled dependant ever attended school? ☐ Yes ☐ No
   If "Yes," please provide complete details.

Most Recent Date (dd/mm/yyyy)	Weekly Hours	Type of School

4. Is the disabled dependant eligible for:
   a) benefits under a government plan? ☐ Yes ☐ No
   b) Health, dental, disability benefits from another group plan? ☐ Yes ☐ No
   If "Yes," to either of the above questions, please give complete details.

5. Are you the sole means of support for the disabled dependant? ☐ Yes ☐ No
   If "No," please explain.

Please provide full details if the dependant was covered as an Overage Disabled Dependant under a previous group insurance plan.

Insurance Company name	Policy Number	Certificate Number	Date Coverage Terminated (mm/dd/yyyy)

SECTION 4: PHYSICIAN INFORMATION - TO BE COMPLETED BY ATTENDING PHYSICIAN

Physician Name (First, Middle Initial and Last)		Office Telephone Number
Address (Number, Street and Apt.)	City/Town	Province / Postal Code
Email Address		Office Fax Number

1. What is the clinical diagnosis, the nature and degree of mental/physical disability? Please provide details.

2. When was the above condition diagnosed? (dd/mm/yyyy)

3. When was the patient examined last? (dd/mm/yyyy)

4. How does the mental/physical disability restrict the patient's ability to engage in normal activities?

5. Does the patient need assistance with activities of daily living? If yes, please provide details.

6. What type of work can the patient perform?

7. Please confirm the dates this patient has been unable to work or attend school full-time due to disability.

8. What is the prognosis?

9. Do you consider the patient to be totally disabled? ☐ Yes ☐ No

10. Is the disability ☐ temporary or ☐ permanent?

11. Are there any additional remarks or comments you can provide?

I declare the information in this section is true to the best of my knowledge.

Signature of Attending Physician **Date** *(mm/dd/yyyy)*

SECTION 5: CERTIFICATION AND AUTHORIZATION

I certify that I (being the plan member, spouse or dependant with the capacity to contract, whichever is applicable) am applying for this benefits coverage/insurance ("Coverage") and that the information provided for this application is true and complete. I understand that the Coverage is insured through a group benefits insurance carrier ("Insurer"). I agree that my Coverage may be denied or terminated at any time by the Insurer as a result of any false, incomplete, or misleading information having been provided in this application. I authorize the Insurer to collect, use, maintain and disclose my personal information relevant to this application ("Information") for the purposes of benefits plan administration, audit and the assessment, investigation, or management of this application, and medical underwriting (collectively, the "Purposes"). I also authorize OTIP to collect, use, maintain and disclose Information for the purpose of benefits plan administration. I am authorized to consent to the collection, use, maintenance, exchange and disclosure of Information pertaining to any minor child who may be the subject of this application for Coverage, for the Purposes, and all of the statements made herein on my own behalf shall apply equally to such minor child.

I understand that the Insurer may investigate this application and may require Information about me for the Purposes, including information regarding activities, income, employment, education and training, health and medical history and treatment, including clinical notes. I authorize any person or organization with Information, including any medical or health professionals, facilities or providers, professional regulatory bodies, any employer, plan administrator, plan sponsor, insurer, investigative agency, and any administrators of other benefits programs to collect, use, maintain and exchange this Information with each other, including OTIP, the Insurer, its reinsurers and/or service providers, for the Purposes. I understand that any Coverage shall not become effective until approved by OTIP and by the Insurer. I authorize the use of my OTIP identification number for the purposes of identification and administration. I agree a photocopy or electronic version of this authorization is valid. I acknowledge that more specific details regarding how and why OTIP and the Insurer collect, use, maintain, and disclose my personal information can be found in OTIP's Privacy Policy available at www.otip.com, or the Insurer's Privacy Policy available at www.manulife.com, or by request.

Signature of Plan Member **Date** *(mm/dd/yyyy)*

A copy of this application form along with any further Information provided to or collected by the Insurer in accordance with this authorization, will be kept in the Insurer's benefits health file. Access to your Information will be limited to:

- The Insurer and its reinsurers and service providers in the performance of their jobs;
- Persons to whom you have granted access; and
- Persons authorized by law.

You have the right to request access to personal information in your file, and where appropriate, to have any inaccurate information corrected.