OTIP
Group Life and Disability Claims
125 Northfield Drive West
Waterloo ON N2L 6K4
Tel: 1-800-267-6847
Fax: 1-877-205-6847 | www.otip.com

OTIP LTD Claim Application - Member Statement

INSTRUCTIONS FOR COMPLETION AND REQUIREMENTS

These instructions explain:

- How to apply for long term disability (LTD) benefits
- Which forms you must complete to notify OTIP Group Life and Disability Claims of your claim
- What will happen after you've submitted this application

You can also log in at: **www.otip.com/Group-Benefits/Administration** to learn more about your specific group LTD plan and coverage details. Your login and password can be obtained from your plan administrator.

For a complete LTD Claim application, we require the following forms submitted to OTIP:

☐ Member's Statement (fully completed, signed and dated by you as the member).

☐ Attending Physician's Statement of Disability (fully completed, signed and dated by your physician; hard copy should be provided by you or directly by your physician). Ensure your physician attaches copies of all unredacted medical documents from the date last worked to present date.

☐ Plan Administrator's Statement (fully completed, signed and dated by your plan administrator/employer and sent directly to OTIP, including job description).

☐ Direct Deposit Authorization for Your Disability Benefit Payments (if applicable, fully completed, signed and dated by you as a member).

To prevent any delays, all forms should be submitted to OTIP Group Life and Disability Claims at least 12 weeks before benefits are payable (if eligible). OTIP will not be liable for claims received outside of the plan requirements.

Completed LTD claim applications should be sent to:

OTIP Group Life and Disability Claims
125 Northfield Drive West
Waterloo ON N2L 6K4
Tel.: 1-800-267-6847
Fax: 1-877-205-6847
Email: **GL&DCadmin@otip.com** (privacy & security cannot be guaranteed)

If you have any questions about your claim, please contact an OTIP representative at 1-800-267-6847.

You can complete this form online and then print it off to sign and submit it as instructed.

For assistance, visit the Frequently Asked Questions (FAQ) at **www.otip.com/group-benefits/forms**.

MEMBER'S STATEMENT

Answer all questions completely and truthfully. Incomplete forms may delay the claim review.

Member Identification

First Name: _____ Middle Name: _____ Last Name: _____

Home Address: _____

City: _____ Province: _____ Postal Code: _____

Telephone Number: _____ Alternate Telephone Number: _____

This number is personal/confidential and OTIP is authorized to leave voice messages relating to your claim:

☐ Yes ☐ No

Mailing Address: *(if different)* _____

Preferred Email Address: _____

(By providing your email address you consent and authorize OTIP to communicate with you via email. You understand that email security cannot be guaranteed because information could be intercepted, corrupted, lost or destroyed and you accept these risks).

What is your language preference? ☐ English ☐ French

Date of Birth: *(mm/dd/yyyy)* _____

For proof of age, please provide a copy of one of the following: your birth certificate, driver's licence, baptismal certificate or passport.

Sex at birth: ☐ Female ☐ Male Preferred Pronoun: _____

Employment Information

1. Occupation: _____
2. Association: _____
3. Ontario College of Teachers Registration Number *(if applicable)*: _____
4. School Board: _____ Grade Level *(if applicable)*: _____
5. Name of School: _____
6. Specific assignment as of date last worked: _____

Description of significant duties (how do you spend your day at work)	Number of hours spent per week at each duty	Are you currently able to perform this duty?
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No

MEMBER'S STATEMENT (CONTINUED)

7. Prior Work Experience:

Years	Roles/Job Title	Employer	City/Town

8. Education Levels:

Years	Degrees/Diplomas	University/College	City/Town

9. Apprenticeship/trade courses or other job training programs:

Trade papers or licenses	
Diplomas/certificates	
On-the-job training/courses	
Other	

10. Wages from other employment:

Specify Source	Employment Start Date *(mm/dd/yyyy)*	Employment End Date *(mm/dd/yyyy)*	Monthly Wages

Claim Information

1. When did your health first become affected?: *(mm/dd/yyyy)* _____
2. Date last worked on a regular basis before work absence began: *(mm/dd/yyyy)* _____
3. From what date has your illness/injury prevented you from working *(if different from #2): (mm/dd/yyyy)*

_____

MEMBER'S STATEMENT (CONTINUED)

4. Is your illness/injury a result of a Motor Vehicle Accident? ☐ Yes ☐ No

Auto Insurer	Name of Adjuster	Contract/Policy #	Claim #	Telephone Number/ Email

5. Is your illness/injury work related? ☐ Yes ☐ No

6. Have you applied for Workplace Safety & Insurance Board benefits? ☐ Yes ☐ No

7. Are you receiving, or do you expect to receive, Workplace Safety & Insurance Board benefits? ☐ Yes ☐ No

Provide approval/denial letter and other supporting documents.

Name of Adjuster	Claim #	If your claim is approved, benefit amount	If your claim has been denied/terminated, have you appealed the decision?	Stage of your appeal
			☐ Yes ☐ No	☐ Oral ☐ Board of Review ☐ Medical Panel ☐ Medical Review ☐ Other

8. Have you applied for any other disability/retirement benefits? ☐ Yes ☐ No

Provide approval/denial letter and other supporting documents.

Benefit type (ie. CPP/QPP, retirement plan, individual plan, etc.)	Claim #	If your claim is approved, benefit amount	If your claim has been denied/terminated, have you appealed the decision?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

9. Describe your illness/injury, its cause and history to date. If injured, indicate the nature of the accident.

MEMBER'S STATEMENT (CONTINUED)

10. How has your specific assignment been impacted?

11. How have your daily activities been impacted?

12. Have you had this illness/injury before? ☐ Yes ☐ No

If yes, please explain:

13. Have you had any prior disability claims? ☐ Yes ☐ No

If yes, name of insurer: Claim Number:

Provide dates: *(mm/dd/yyyy)* From: To:

Treatment Information

1. Name all your current treatment providers related to this illness/injury (e.g. CBT, drug/alcohol, group therapy, marital therapy, day hospital program, physiotherapy, psychotherapy, etc.).

Name of provider or facility	Specialty	Date treatment began *(mm/dd/yyyy)*	Frequency of visits	Date of last visit *(mm/dd/yyyy)*	Progress

MEMBER'S STATEMENT (CONTINUED)

2. What medication have you received:

Medication(s)

Name	Initial dosage and date started *(mm/dd/yyyy)*	Current dosage and date changed if applicable *(mm/dd/yyyy)*	Frequency	Response

Were you hospitalized for this illness/injury? ☐ Yes ☐ No

If yes, provide the date(s) *(mm/dd/yyyy)* and hospital name(s):

3. Have you noticed any changes in your illness/injury since the onset of treatment?

4. What other treatment recommendations have been suggested?

Return-to-Work Information

1. Have you tried to return to work? ☐ Yes ☐ No

   If yes, please provide dates: *(mm/dd/yyyy)* From: _____ To: _____

   From: _____ To: _____

2. When do you expect to be able to return to your specific assignment? *(mm/dd/yyyy)* _____

3. If you are not able to return to work, what is preventing you?

INCOME DECLARATION
(Attached are other sources of reportable income)

1. I agree to notify OTIP of any reportable income that:

   a) I receive or become entitled to; or

   b) A member of my family receives or becomes entitled to; as a result of my medical condition, for or during the period of my disability claim.

2. I agree to provide this notice within 30 calendar days after income is first received or awarded.

3. I recognize and accept my obligation to repay any benefits that are overpaid according to the terms of the group plan as a result of my entitlement to other income. I agree to repay such amounts immediately after I am notified of an overpayment.

Initial _____

DIRECT DEPOSIT FOR DISABILITY BENEFIT PAYMENTS
(This service is subject to the approval of your claim)

OTIP's Direct Deposit service is a convenient, secure, no-charge way to deposit your disability benefit payments directly into your chequing/savings account. Direct Deposit can help make your money management more convenient and assures you receive your funds on time without disruptions or delays due to mail service.

You can obtain a Direct Deposit form from our website at www.otip.com/group-benefits/forms, your financial institution website, or provide us with a photo/scanned VOID cheque. If not provided we will use banking information previously provided to OTIP's Early Intervention Department (if applicable).

Initial _____

THIRD-PARTY COMMUNICATION

If you consent to OTIP disclosing information related to your claim with other individuals (e.g. spouse, relative, affiliate representative), please complete the following:

I authorize and consent that OTIP can disclose any information related to my claim for long term disability benefits to the following individuals:

Name		**Relationship**		**Phone**	
Name		**Relationship**		**Phone**	

If I do not wish OTIP to disclose information to the individuals noted above, I understand that I am responsible to notify OTIP in writing of this change.

Initial _____

CERTIFICATION AND AUTHORIZATION

Fraudulent claims are costly for all participants in a benefit plan and OTIP will verify the accuracy of the information given in support of your claim.

I certify that the information in this form, and any further verbal or written statement provided by me in the future, is true and complete to the best of my knowledge. I understand that the Trustees of the Ontario Teachers Insurance Plan and OTIP/RAEO Benefits Incorporated ("OTIP") will investigate my claim and may require personal information about me, including information regarding my activities, income, employment, education and training, health, and medical history and treatment, including clinical notes (collectively referred to in this authorization as the "Information").

I authorize OTIP and its service providers to collect, use, maintain and disclose Information needed for the purposes of underwriting, benefits plan administration, audit, investigation and management of my claim, including independent medical assessments and if applicable, assessment of Waiver of Premium benefits on my Group Life insurance (collectively referred to in this authorization as the "Purposes") with any person or organization who has Information about me, including any plan administrator, plan sponsor, health care professional, health care institution, medical consultant, pharmacy, and any other medically-related facility, rehabilitation provider, insurer, reinsurer, investigative agency, administrator of government benefits or other benefit programs, and the Medical Information Bureau.

I authorize OTIP to collect, use and maintain Information from my employer relevant to the administration of my claim and the planning and managing of my rehabilitation and/or return to work. I also authorize OTIP to disclose Information related to my claim status and the general nature of my medical condition, prognosis, and restrictions and limitations to my employer for the purpose of planning and managing my rehabilitation and/or return to work.

I agree that both my claim and my coverage may be denied or terminated as a result of my providing false, incomplete, misleading Information and/or if there is suspicion of fraud or plan abuse.

I agree to refund any monies that I may owe to OTIP in accordance with the provisions of the benefits plan with OTIP, and I authorize OTIP to deduct such monies from my benefits.

I consent to the disclosure by the Ontario Teachers' Pension Plan (OTPP) or Ontario Municipal Employees Retirement System (OMERS) to OTIP of all personal information concerning my pension benefits in their custody or control, yearly and as required.

I agree that my consent is valid for the duration of my claim. I agree that a photocopy or electronic version of this authorization shall be as valid as the original. I understand that OTIP's Privacy Policy is available at www.otip.com or by request.

Member's Last Name (please print): _____ First Name: _____

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

Any Information provided to or collected by OTIP in accordance with this authorization, will be kept in a benefits health file. Access to your Information will be limited to:

- OTIP employees, OTIP representatives, service providers, insurers and/or reinsurers (if applicable) 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 the information in your file, and, where appropriate, to have any inaccurate information corrected.