



OTIP RAEO®

OTIP LTD Appeals
125 Northfield Drive West
Waterloo ON N2L 6K4

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Long Term Disability Appeal Member's Statement

MEMBER INFORMATION (Please print neatly.)

Name (Last, First and Middle Initial)

Address (Number, Street and Apt.)

City

Province

Postal Code

Home Telephone

Cell Telephone

Claim #

Email Address

Reason for appealing the decision:

1. Have you returned to work? ☐ Yes ☐ No ☐ Not applicable

If Yes:

Did you return: ☐ Full time ☐ Part time

Date you returned to work (mm/dd/yyyy)

If No/Not applicable:

Have you continued to work? ☐ Yes ☐ No ☐ Not applicable

If No, when did you stop working? (mm/dd/yyyy)

2. Are you receiving or earning any other income? ☐ Yes ☐ No

If Yes, please explain:

3. What are your current restrictions, limitations and symptoms? (Please use a separate page if more space is required)

4. Have you had surgery or is surgery pending? Please provide the type of surgery and date it was completed or is scheduled for.

Type of Surgery

Date of Scheduled Surgery (mm/dd/yyyy)

Date of Completion (if applicable) (mm/dd/yyyy)

5. Have there been any changes in your treatment providers or frequency of treatment since the date your claim was denied or terminated? If so, please provide the information below:

Provider Name	Specialty	Address	First appointment (mm/dd/yyyy)	Last appointment (mm/dd/yyyy)

6. Please list your current medications (or attach pharmacy records):

Medication name	Dosage	Start date (mm/dd/yyyy)	Prescribing physician

CERTIFICATION AND AUTHORIZATION

Please note: The permissions below were previously agreed upon in your signed LTD application. To continue with your appeal, please review the certification and authorization statements and sign at the bottom of both pages.

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, assessment, investigation and management of my claim, including independent medical assessments (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 authorize OTIP to assess my Waiver of Premium benefits on my Group Life insurance, if applicable, using the Information provided for the Purposes of my claim for long term disability (LTD) benefits.

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 Board (OTPPB) 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, but for the purposes of audit, for the duration of the plan.

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 Signature

Date (mm/dd/yyyy)

AUTHORIZATION TO COMMUNICATE BY EMAIL

Protecting your personal information and respecting your privacy is important to us, which is why the Trustees of the Ontario Teachers Insurance Plan and OTIP/RAEO Benefits Incorporated ("OTIP") take precautions when communicating your personal information. We also believe it is important to inform you of the risks associated with certain communications, such as email. Please read the below and sign this form if you understand the risks and agree to communicate via email.

While email is a quick and convenient way to communicate, we need to make you aware that the security of email cannot be guaranteed. By using email to communicate with OTIP, you understand that our email communications may include your personally identifiable information, including but not limited to: sensitive personal information such as medical/health, employment, and financial information.

The risks of using email include, but are not limited to:

- Email senders may accidentally misaddress an email, resulting in it being sent to unintended or unknown recipients.
- Employers (e.g. school boards) and online services may have a legal right to monitor, inspect and/or keep emails that pass through their networks and systems.
- Email can be intercepted, altered, forwarded, stored, and used without authorization or detection of the sender or recipient as it travels between internet service providers.
- Use of email to discuss sensitive information can increase the risk of such information being disclosed to third parties as emails are replied to and/or forwarded.
- Email is indelible – even after the sender and recipient have deleted their copies, back-up copies may exist on a computer or in cyber-space.

By consenting to use email communications to discuss matters related to your LTD application for coverage, you agree to:

- Inform us of any changes to your email address(es).
- Inform us if you wish to withdraw your consent for the use of email communications by sending an email from an email address above or alternate written withdrawal.
- Hold OTIP and its authorized service providers harmless of all losses, expenses, damages, and costs related to electronic communications.

I understand and accept the risks associated with email communications and consent and authorize OTIP to use email when communicating with me regarding my LTD application for coverage.

Member's Signature

Email Address

Date (mm/dd/yyyy)

MAILING INSTRUCTIONS

Please return all completed documentation to:

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