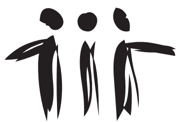

OTIP RAEO®

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

1.800.267.6847 | www.otip.com

Application for Insurance and Evidence of Insurability (RTIP/ARM)

IMPORTANT: (Please print all answers)

1. Check (✔) the appropriate box to indicate the type of coverage for which you are applying.
   ☐ PLAN MEMBER ONLY ☐ PLAN MEMBER AND SPOUSE ☐ PLAN MEMBER, SPOUSE AND DEPENDANTS ☐ SPOUSE AND/OR DEPENDANTS
2. Please ensure that **ALL SECTIONS** are completed.
3. **If required, retain a copy for your files.**

SECTION 1: MEMBER BASIC PERSONAL INFORMATION

Plan Member Name (First, Middle Initial and Last)			Gender ☐ Male ☐ Female	
Address (Number, Street and Apt.)		City/Town	Province	Postal Code
Home Telephone Number	Work Telephone Number	Date of Birth *(mm/dd/yyyy)*		
OTIP ID Number	Plan/Policy Number	Email Address		

SECTION 2: MEMBER BENEFITS (PLEASE CHECK THE BENEFIT(S) YOU ARE APPLYING FOR)

☐ Late entrant ☐ Increase in coverage

☐ Extended health care coverage: ☐ Single ☐ Family ☐ Dependant

SECTION 3: PLAN MEMBER INFORMATION

Plan Member's Name (First, Middle Initial and Last)				
Height __________ m __________ cm __________ ft __________ in	Weight __________ kg __________ lbs	Have you smoked (cigarettes, cigars, pipe, etc.) or used tobacco in any other form within the last 12 months? ☐ Yes ☐ No		
Have you lost or gained more than 10 lbs during the last 12 months? ☐ Yes ☐ No If "Yes," please answer the following:		What was the amount of weight change? __________ kg __________ lbs	Was this a gain or a loss?	
Reason For Weight Loss/Gain?				
Name of Personal Physician (First, Middle Initial and Last)				
Address of Personal Physician (Number, Street and Apt.)			Physician's Telephone Number	
City/Town			Province	Postal Code

SECTION 4: SPOUSE INFORMATION (TO BE COMPLETED IF APPLYING COVERAGE FOR SPOUSE.)

Spouse's Name (First, Middle Initial and Last)				
Sex ☐ Male ☐ Female	Date of Birth *(mm/dd/yyyy)*	Home Telephone Number	Work Telephone Number	
Height __________ m __________ cm __________ ft __________ in	Weight __________ kg __________ lbs	Have you smoked (cigarettes, cigars, pipe, etc.) or used tobacco in any other form within the last 12 months? ☐ Yes ☐ No		
Have you lost or gained more than 10 lbs during the last 12 months? ☐ Yes ☐ No If "Yes," please answer the following:		What was the amount of weight change? __________ kg __________ lbs	Was this a gain or a loss?	
Reason for weight loss/gain				
Is the Name of Personal Physician the same as the member's? ☐ Yes ☐ No If "No," please provide.				
Name of Personal Physician (First, Middle Initial and Last)				
Address of Personal Physician (Number, Street and Apt.)			Physician's Telephone Number	
City/Town			Province	Postal Code

SECTION 5: DEPENDANT STATEMENT

Please provide the following information for each dependant to be insured.
To be completed when dependants are applying for coverage.

Complete Name of Eligible Dependant	Gender	Currently a full-time student?	Relationship to Plan Member	Date of Birth (mm/dd/yyyy)	Height ☐ m ☐ cm ☐ ft ☐ in	Weight ☐ kg ☐ lbs
	☐ Male ☐ Female	☐ Yes ☐ No				
	☐ Male ☐ Female	☐ Yes ☐ No				
	☐ Male ☐ Female	☐ Yes ☐ No				
	☐ Male ☐ Female	☐ Yes ☐ No				

Name of Dependant's Personal Physician (First, Middle Initial and Last)		Physician's Telephone Number	
Address of Personal Physician (Number, Street and Apt.)	City/Town	Province	Postal Code

I confirm that the above member and dependants are currently enrolled in a provincial health plan, e.g. OHIP. ☐ Yes ☐ No

SECTION 6: MEDICAL QUESTIONS FOR PROPOSED INSURED

COMPLETE ALL QUESTIONS BELOW on behalf of ALL applicants. Provide full details to ALL YES QUESTIONS.
If you require more room for YES answers, please attach a separate sheet (signed and dated).

	Plan Member	Spouse	Dependant(s)
1. During the past 12 months have you:			
(a) flown as a pilot, student pilot or crew member or have any intention of doing so?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
(b) engaged in racing, underwater diving, parachuting or any other hazardous sport or have any intention of doing so?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
2. Have you:			
(a) ever applied for or received benefits, compensation or pension because of sickness or injury?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
(b) ever had an application for life or health insurance declined, postponed or modified in any way?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
(c) been absent from work for medical reasons during the last 5 years?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
(d) recently received any treatment/medications?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
(e) any condition which might require medical consultation, hospitalization or future surgical or psychiatric treatment?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
(f) any family history of any inherited or familial disease (e.g. Huntington's Chorea, diabetes, heart or kidney disease)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
3. Have you ever consulted a physician for, ever been treated for or had any known identification of:			
(a) chest pain, blood vessel disease, heart disorder or heart attack or stroke?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
(b) high blood pressure?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
(c) allergies or skin disorders, including growths, cysts or tumours?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
(d) glandular disorders, including thyroid disorders and diabetes?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
(e) epilepsy, neurological disorder (e.g., Multiple Sclerosis, Parkinson's)?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
(f) nervous or mental disorder or an emotional condition such as anxiety or depression?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
(g) excessive use of alcohol or drugs?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
(h) lung disorders?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
(i) bowel, stomach or liver disorders?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
(j) cancer?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
(k) disorder of the kidney, urine or genital organs?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
(l) arthritis, rheumatism or fibromyalgia?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
(m) disorders of the muscles or bones including the back, spine or joints?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
(n) immune deficiency disorder including AIDS or AIDS-related complex (ARC) or any generalized enlargement of the lymph glands or any test results indicating possible exposure to the AIDS (e.g. HTLV-III, LAV) virus?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
(o) anemia, or other blood disorders?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
4. Have you ever had any physical impairment, condition, disease or disorder or chronic symptoms including Chronic Fatigue Syndrome or chronic pain not covered above?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

SECTION 6: MEDICAL QUESTIONS FOR PROPOSED INSURED (CONTINUED)

If you answered "YES" to any of the questions in Section 6, please provide full details.
If more space is needed, use another form or sheet of paper (both must be signed and dated).

Question Number	Name of Person (First and Middle)	Details or Name of Condition	Date and Duration (mm/dd/yyyy)	Treatment and Results (Recovery/Remaining Effects)	Names and Addresses of Physicians and Hospitals

SECTION 7: 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 employee 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)* ____________________

Signature of Spouse (required only if evidence regarding insurability of spouse is provided in this form) ____________________ Date *(mm/dd/yyyy)* ____________________

Signature of Dependant (over the age of 18) ____________________ 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's representatives, OTIP's insurer and their 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 the personal information in your file, and, where appropriate, to have any inaccurate information corrected.

MAILING INSTRUCTIONS

Please return all completed documentation to:

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

QUESTIONS?

OTIP
1-800-267-6847

OTIP Benefits Services
1-866-783-6847