OTIP RAEO®

ONTARIO TEACHERS INSURANCE PLAN
125 Northfield Drive West
PO Box 218
Waterloo ON N2J 3Z9

519.888.9683
1.800.267.6847

Occasional Education Employee Insurance Plan Application Form

IMPORTANT: (Please print all answers)

◗ Please ensure that **ALL SECTIONS** are completed. ◗ **If required, retain a photocopy for your files.**

BASIC PERSONAL INFORMATION

Name (Last, First and Middle Initial)		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)*	E-mail Address		
Desired Effective Date of Coverage *(mm/dd/yyyy)* / 01 /	School Board		

COVERAGE SELECTIONS

☐ LIFE (including matching amount of AD&D) and
☐ LTD
☐ EXTENDED HEALTH CARE (Including Travel)
☐ DENTAL CARE

If your selection includes extended health and dental care, indicate if coverage is for:
☐ Single ☐ Couple ☐ Family

If your selection includes LTD, indicate plan choice:
☐ A - 2 year benefit ☐ B - 3 year benefit

LIST OF FAMILY MEMBERS TO BE COVERED FOR EXTENDED HEALTH & DENTAL CARE

First Name and Initial *(Provide Last Name if Different From Applicant's)*	Gender	Date of Birth *(mm/dd/yyyy)*	Current Age
Applicant			
Spouse			
Dependant Child			
Dependant Child			
Dependant Child			

LEVEL OF ELIGIBILITY

Number of days worked in the last school year (min. 10) or, if greater, number of days contracted for this school year.

WORK SCHEDULE	LIFE & AD&D AMOUNT	LTD BENEFIT
☐ 10-39	$10,000	$ 400
☐ 40-79	$20,000	$ 600
☐ 80-119	$30,000	$ 900
☐ 120+	$40,000	$1,200

DESIGNATION OF BENEFICIARY

DESIGNATION OF BENEFICIARY (If more space is required, please complete a second form and attach)

	BENEFICIARY'S LAST NAME	FIRST NAME	INITIAL	RELATIONSHIP	PERCENTAGE
1.					
2.					

Under the laws of Quebec, any designation of a spouse as a beneficiary is irrevocable unless stipulated to be revocable.

☐ I hereby declare and stipulate that the beneficiary designation(s) made on this form is (are) revocable.

Note: If you designate a minor child as the beneficiary of your insurance proceeds, these proceeds will be paid into court, unless a trustee is appointed to receive such benefits on behalf of such child.

Trustee Appointment (you may wish to consult a lawyer before appointing a Trustee):

I hereby appoint my _____ (Spouse (Brother etc.,)) , _____ (Name) as the Trustee to receive the Benefits on behalf of my minor beneficiary.

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

I hereby designate the above beneficiary to receive any amount due on my death while insured under this Group Policy.

COORDINATION OF BENEFITS – EXTENDED HEALTH AND DENTAL CARE

Do you or your dependants have coverage for these benefits under another plan? ☐ Yes (See below) ☐ No

If yes, complete the following: Policy/Group no. _____ Agreement/ID no. _____

Name and address of insurance company/organization: _____

A subscriber's claim should always be submitted to his or her own insurance carrier first. Any remaining eligible expenses may then be paid by the spouse's insurance carrier. Claims for dependant children should first be submitted to the plan of the parent whose month and day of birth come earliest in the calendar year. Any remaining eligible expenses may then be paid by the spouse's carrier.

MEDICAL QUESTIONS FOR PROPOSED INSURED

COMPLETE ALL QUESTIONS BELOW on behalf of ALL applicants. Provide full details to ALL YES ANSWERS.

If you require more room for YES answers, please attach a separate sheet (signed and dated).

	Applicant	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, 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

Please provide full details to ALL YES answers.
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 or Remaining Effects)	Names and Addresses of Physicians and Hospitals

APPLICANT INFORMATION

Applicant Name (First, Middle Initial and Last)

Height	Weight	Have you smoked (cigarettes, cigars, pipe, etc.) or used tobacco in any other form within the last 12 months?
_____ m _____ cm _____ ft _____ in	_____ kg _____ lbs	☐ 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

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	Relationship to Applicant	Date of Birth *(mm/dd/yyyy)*	Height ☐ m ☐ cm ☐ ft ☐ in	Weight ☐ kg ☐ lbs
	☐ Male ☐ Female				
	☐ Male ☐ Female				
	☐ Male ☐ Female				
	☐ Male ☐ Female				

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

Has your spouse smoked (cigarettes, cigars, pipe, etc.) or used tobacco in any other form within the last 12 months? ☐ Yes ☐ No

CERTIFICATION AND AUTHORIZATION

I certify that I am applying for this benefits coverage/insurance ("Coverage") and that the information provided about me, my spouse or dependants, whichever is applicable, for this application is true and complete. **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 this application. **I authorize** OTIP and its 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 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 OTIP and/or its 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, insurer, investigative agency, and any administrators of other benefits programs to collect, use, maintain and exchange this information with each other and with OTIP, its insurer, their reinsurers and/or service providers, for the Purposes. **I understand** that any Coverage shall not become effective until approved by OTIP and its insurer. **I authorize** the use of my employee number for the purposes of identification and administration and as my identification number. **I agree** a photocopy or electronic version of this authorization is valid. **I acknowledge** that more specific details regarding how and why OTIP collects, uses, maintains, and discloses my personal information can be found in OTIP's Privacy Policy available at www.otip.com or by request.

Signature of Applicant

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:

ONTARIO TEACHERS INSURANCE PLAN
125 Northfield Drive West
PO Box 218
Waterloo ON N2J 3Z9