OTIP RAEO

ONTARIO TEACHERS INSURANCE PLAN
125 Northfield Drive West
P. O. Box 218
Waterloo ON N2J 3Z9
(519) 888-9683
1-800-267-6847

EXTENDED HEALTH AND DENTAL CHANGE FORM

BASIC PERSONAL INFORMATION (MUST BE COMPLETED)

NAME _____ LAST _____ FIRST _____ MIDDLE

GENDER F ☐ M ☐

ADDRESS _____

CITY _____

POSTAL CODE _____ PHONE _____ – _____

EMPLOYEE TYPE (CHECK ONE)

INDICATE MEMBERSHIP OF:

OECTA	ELEM ☐	ADMINISTRATION	☐
	SEC ☐	CLERICAL	☐
ETFO	☐	TRADESPERSON	☐
OSSTF TEACHER	☐	OTHER _____	

IDENTIFICATION NO. _____ EMPLOYEE NO. _____

BOARD _____

DATE OF BIRTH ___ MONTH ___ DAY ___ YEAR

POLICY NO. _____ E-MAIL ADDRESS _____

Reason for Change: _____

Date Change Occurred: ___ MONTH ___ DAY ___ YEAR

This form must be completed and signed within 31 days of the occurred date to prevent the member and his/her dependent(s) from being considered as late entrants.

Coverage: Change ☐

EHC		Dental	
Family to Single	☐	Family to Single	☐
Single to Family	☐	Single to Family	☐

Please complete the following section(s) for individual registration purposes.

Spouse: Add ☐ Delete ☐ Change ☐

First Name _____ Last Name _____ Gender _____ Date of Birth (mm/dd/yyyy) ___ / ___ / ___

Dependent Status: Disabled ☐ (provide doctor's letter) Overage - Attending College/University ☐ (If over age **21**, please complete overage dependent form)

Children: Add ☐ Delete ☐ Change ☐

First Name _____ Last Name _____ Gender _____ Date of Birth (mm/dd/yyyy) ___ / ___ / ___

Add ☐ Delete ☐ Change ☐

First Name _____ Last Name _____ Gender _____ Date of Birth (mm/dd/yyyy) ___ / ___ / ___

Add ☐ Delete ☐ Change ☐

First Name _____ Last Name _____ Gender _____ Date of Birth (mm/dd/yyyy) ___ / ___ / ___

Signature _____ Date (mm/dd/yyyy) _____