OTIP RAEO®

ONTARIO TEACHERS INSURANCE PLAN
125 Northfield Drive West
PO Box 218
Waterloo ON N2J 3Z9
519.888.9683
1.800.267.6847

Group Benefits Application Form

Basic Personal Information (Must be completed)

Name (Last, First and Middle Initial)

Gender ☐ Male ☐ Female

Address (Number, Street and Apt.)

City Prov. Postal Code

Home Telephone Number ( ) Work Telephone Number ( )

E-mail Address

Employee Number Policy Number

School Board/District

Indicate membership of:

☐ AEFO ☐ Administration
☐ ETFO ☐ Clerical
☐ OECTA Elementary ☐ Tradesperson
☐ OECTA Secondary ☐ Retiree
☐ OSSTF Teacher ☐ Other ____________

Date of Birth *(mm/dd/yyyy)* Date of Hire *(mm/dd/yyyy)*

Date Eligible for Benefit *(mm/dd/yyyy)* Effective Date *(mm/dd/yyyy)*

Yearly Gross Salary (Including allowances, excluding overtime) $ ______ .00

A Long Term Disability Income Protection Insurance

☐ Yes, I wish to have the coverage

B Dependant Group Life

☐ Yes, I wish to have the coverage

C Basic Life (See details for your group)

Base Amount $ ______ .00 AD&D Base Amount $ ______ .00

Optional/Spousal Life

If you are interested in applying for Optional/Spousal Life Insurance, please see your plan administrator for the necessary forms.

D 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.

Contingent Beneficiary (alternate beneficiary, should your chosen beneficiary predecease you)

Last Name	First Name	Initial	Relationship

E Extended Health Coverage

☐ Yes, I wish to have the coverage
☐ Single ☐ Family
☐ No, I am covered by my spouse's plan
☐ No, I waive my right to coverage

Dental Coverage

☐ Yes, I wish to have the coverage
☐ Single ☐ Family
☐ No, I am covered by my spouse's plan
☐ No, I waive my right to coverage

Date of Birth *(mm/dd/yyyy)*	Individual Registration First and Last Name	Gender M – Male F – Female
	Employee	
	Spouse	
	Child	
	Child	

Does your spouse have any dental or supplementary health insurance coverage? ☐ Yes ☐ No Policy Number ____________

Name of spouse's insurance carrier ____________ Spouse's identification number ____________

Please indicate with a "✓" in the appropriate box, each benefit covered under your spouse's plan.

☐ Semi-private Hospital ☐ Prescription Drugs ☐ Vision ☐ Dental ☐ Extended Health Care

F Waiver of Benefits (To be completed and signed by the Plan Member if waiving benefits)

Only those benefits which are not a condition of employment can be waived.

I have been given the opportunity to apply for coverage, but do not wish to participate. I understand that if I wish to request coverage at a later date, I will be required to furnish, at my own expense, (and if applicable, for my eligible dependant(s)) evidence of insurability.

I wish to waive the following benefit(s): ☐ LTD ☐ Dependant Group Life ☐ Basic Life ☐ AD&D ☐ Extended Health Care ☐ Dental

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

Agreement, Acknowledgement and Authorization

I hereby make application for benefits as outlined above and certify that the information disclosed herein is accurate and complete. I consent to such information being used for the purpose of understanding my needs, evaluating my eligibility to the plan, providing me with ongoing services, protecting us both against error and fraud and complying with various legal requirements.

I hereby confirm the designation of beneficiary listed to be true and correct as appointed by me. I hereby designate the above beneficiary to receive any amount due on my death while insured under this group policy.

I further understand that, unless this application is completed and submitted within 31 days of my becoming eligible to secure benefits under the plan, my application will be subject to the rules of the plan as follows: a late applicant will be required to submit proof of insurability at his/her own expense (attach if applicable); and a new employee shall not be considered a late applicant if the application is made within 31 days of becoming eligible.

I authorize the Board to make payroll deductions as applicable and authorize the use of my employee number for the administration of my benefits applied for under this application. I further authorize the plan administrator, OTIP, to act on my behalf in dealing with the insurance carrier of the existing policy or any successor policy, concerning my application for group insurance, changes in insurance, notification of insured information and any other administrative matters. I understand that this authorization terminates on the earlier of the change in my employment status with the Group/Board which affects my eligibility under the policy, or a termination of the insurance between the Group/Board and the plan administrator, OTIP.

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