OTIP RAEO®

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

1.866.783.6847
www.otip.com

Application for Insurance and Evidence of Insurability

IMPORTANT: (Please print all answers)

1. Please consult your plan administrator for the type of coverage available under your plan. 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 photocopy for your files.**

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)*	Date of Hire *(mm/dd/yyyy)*
Employee Number	School Board	Email Address	
Yearly Gross Salary	Indicate Membership of: ☐ AEFO ☐ OECTA ELEM ☐ OECTA SEC ☐ ETFO ☐ CLERICAL ☐ RETIREE ☐ OSSTF TEACHER ☐ ADMINISTRATION ☐ TRADESPERSON ☐ OTHER _____		

MEMBER BENEFITS *Please indicate the benefit(s) you are applying for*

☐ Late entrant ☐ Increase in coverage

☐ Extended health care coverage ☐ Single ☐ Family ☐ Dependant

☐ Dental coverage* ☐ Single ☐ Family ☐ Dependant

* Restrictions on dental may apply in the first year of coverage. Please contact your plan administrator for information on late entrant restrictions.

☐ Dependant group life Policy number_____

☐ Member basic life Policy number_____

Plan member's current life coverage $_____

Amount requested for increase in coverage $_____

☐ Long term disability Policy number_____ Division number_____

☐ Other_____

If you are applying for member basic life, a beneficiary designation is required. Please complete a Change of Beneficiary form. Please contact OTIP Benefits Services at 1-866-783-6847.

If you are applying for dependant group life, the plan member is the designated beneficiary. No beneficiary designation is required.

Please ensure you sign and date the final page of this form before returning it to OTIP.
Incomplete applications will result in processing delays.

PLAN MEMBER INFORMATION

Plan Member's 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?	What was the amount of weight change?	Was this a gain or a loss?
☐ Yes ☐ No If "Yes," please answer the following:	_____ kg _____ lbs	

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 Plan Member**	**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

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

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		Children	
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

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

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 OTIP has insured the Coverage 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, insurer, investigative agency, and any administrators of other benefits programs to collect, use, maintain and exchange this information with each other, 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 the 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 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)* _____

A copy of this application form will be kept on file at OTIP. Any further Information provided to or collected by the Insurer in accordance with this authorization, will be kept in the Insurer's benefits health file. Access to your Information will be limited to:

- The Insurer and its 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. More detailed information concerning how and why the Insurer, Manulife Financial, collects, uses and discloses personal information is available at www.manulife.ca or by requesting a copy from the plan sponsor.

MAILING INSTRUCTIONS

Please return all completed documentation to:

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