OTIP RAEO®

ONTARIO TEACHERS INSURANCE PLAN
125 Northfield Drive West
PO Box 218
Waterloo ON N2J 3Z9
Phone: 1.866.783.6847
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Extended Health and Dental Coverage Change 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	Identifcation Number (found on your benefits card)	Date of Birth *(mm/dd/yyyy)*	Date of Hire *(mm/dd/yyyy)*

Reason for Change (Must be completed)

Reason for Change: _____

(e.g., birth or adoption of a child, change in marital status, eligibility for common-law status, change in spouse's coverage, etc.)

Date Change Occurred: *(mm/dd/yyyy)* _____

Please note: for common-law status, indicate the date you started living together.

This form must be completed and signed within 31 days of first becoming eligible to make a change under your contract to prevent the member and his or her dependant(s) from being subject to late entrant requirements (e.g., medical approval and associated costs, decrease in coverage for the first year).

Benefit(s) to Change

Health care: ☐ Family to Single ☐ Single to Family

Dental care: ☐ Family to Single ☐ Single to Family

My name has changed:

From: _____

To: _____

Dependant Information Change

Spouse Information

	First and Last Name	Date of Birth *(mm/dd/yyyy)*	Gender M – Male F – Female
☐ Add ☐ Delete			

What group benefits does your spouse have through an employer?

Health Care: ☐ Single ☐ Family ☐ Waived ☐ None

Dental Care: ☐ Single ☐ Family ☐ Waived ☐ None

Insurance Company Name: _____ Policy Number: _____ Identifcation Number: _____

Dependant Information

	First and Last Name	Date of Birth *(mm/dd/yyyy)*	Gender M – Male F – Female	Full-Time Student		Disabled	
				Yes	No	Yes	No
☐ Add ☐ Delete							
☐ Add ☐ Delete							
☐ Add ☐ Delete							
☐ Add ☐ Delete							

Special Note:

If you checked Yes under Full-Time Student, and your dependant is over the maximum age listed in your contract, please complete an overage dependant form. This form can be found online at www.otipservices.com.

Step children must reside with the plan member in order to be eligible under the plan.

If you checked Yes under Disabled, please contact an OTIP Benefits Services representative to review eligibility requirements.

Agreement, Acknowledgement and Authorization

I hereby make application for a change in benefits as outlined above and certify that the information disclosed herein is accurate and complete and 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.

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