



OTIP RAE0

ONTARIO TEACHERS INSURANCE PLAN
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GROUP BENEFITS APPLICATION FORM
LIFE AND LONG TERM DISABILITY
DISTRICT 18 - UPPER GRAND DSB SECONDARY TEACHERS

BASIC PERSONAL INFORMATION (MUST BE COMPLETED)

NAME (LAST, FIRST, MIDDLE), GENDER (F, M), ADDRESS, CITY, POSTAL CODE, PHONE, E-MAIL ADDRESS, EMPLOYEE NO., DATE OF BIRTH (MONTH, DAY, YEAR), DATE OF HIRE WITH BOARD (MONTH, DAY, YEAR), EFFECTIVE DATE (MONTH, DAY, YEAR), YEARLY GROSS SALARY (INCLUDING ALLOWANCES, EXCLUDING OVERTIME) \$

A BASIC LIFE - Policy L7018-902 1 x ANNUAL SALARY (mandatory)

ADDITIONAL BASIC LIFE (Non-Mandatory, member paid)

1 x ANNUAL SALARY, 2 x ANNUAL SALARY, 3 x ANNUAL SALARY, 4 x ANNUAL SALARY, NO, I WAIVE MY RIGHT TO ADDITIONAL BASIC LIFE (Complete Section E), Additional basic life maximum = \$300,000, Overall combined maximum = \$600,000

AD&D BENEFIT - Policy BSC9028313

MATCHES BASIC & ADDITIONAL LIFE COVERAGE
ADDITIONAL BASIC AD&D - MEMBER PAID

B DEPENDANT LIFE - Policy L7018-902

YES SPOUSE \$4,000 CHILD(REN) \$2,000, NO, I WAIVE MY RIGHT TO DEPENDANT LIFE (Complete Section E)

C LONG TERM DISABILITY

COVERAGE MANDATORY BENEFIT
Policy #L7018-902

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

Table with 5 columns: BENEFICIARY'S LAST NAME, FIRST NAME, INITIAL, RELATIONSHIP, PERCENTAGE. Rows 1 and 2 for beneficiary information.

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)

Please have someone other than your designated beneficiary witness your signature.

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

E WAIVER OF BENEFITS (To be completed and signed by 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 dependent(s)) evidence of insurability.

I wish to waive the following benefit(s): DEPENDANT LIFE, ADDITIONAL BASIC LIFE

Plan Member's Signature X, Date (mm/dd/yyyy)

I hereby make application for 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.

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.

Note: A Witness Signature is required in the Beneficiary Designation Box above.

Date (mm/dd/yyyy)

Signature X

Name (please print)