ARM APPLICATION FORM

Please return to: PO Box 218, Waterloo ON N2J 3Z9 | Fax: 1-888-646-3842

Benefits are administered by OTIP and underwritten by Manulife Financial. **Please print using a ballpoint pen.**

Section A | General Information

Date of Birth mm| dd| yy|	Applicant's Last Name	First Name	Middle Initial
Address		Apt.	Sex
City/Town	Province	Postal Code | | | | | | |	
Home Telephone No.	Alternate Telephone No.	Email Address	
I prefer all correspondence in: ☐ English ☐ French			

First Name & Middle Initial (Provide last name if different from applicant)	**Date of Birth**	**Sex**	**Complete if you have an eligible dependent student over the age of 21.** School Year Start	School Year End	Name of School
Spouse/Partner	mm| dd| yy|				
Dependent Child	mm| dd| yy|				
Dependent Child	mm| dd| yy|				
Dependent Child	mm| dd| yy|				

Co-ordination of Benefits (COB) Are you, your spouse or dependants covered under any other plan?	☐ Yes ☐ No	Name of other insurance company	Policy/Group No.	ID/Certificate No.

Section B | Eligibility

I wish to be covered under an ARM plan starting: mm\| **01**\| yy\|

Within the last 60 days: If you select any of the three options below, complete the gold Policy/Group No. below.

☐ I have been insured as an active member under a group health benefits plan.	Plan Termination Date mm| dd| yy|
☐ I have been insured as a retired member under a group health benefits plan.	Plan Termination Date mm| dd| yy|
☐ My current health plan is not terminating and I am looking to co-ordinate my benefits.	Please call OTIP or visit www.otip.com/forms and download the Application for Insurance and Evidence of Insurability for RTIP/ARM members.
Policy/Group No.	Identification/Certificate No.
Insurance Company Name	
☐ I have not been covered under a group health benefits plan in the last 60 days.	Please call OTIP or visit www.otip.com/forms and download the Application for Insurance and Evidence of Insurability for RTIP/ARM members.

Section C | Coverage Selection	(Select your options below and fill in the appropriate information.)	Monthly Premium
ARM Original 4000	☐ Single ☐ Couple ☐ Family	
Health Care	$4,000 prescription drug maximum.	$
Dental Coverage (optional)	☐ Single ☐ Couple ☐ Family	$
Total Premium (add all choices)		$
ARM Prestige 2500	☐ Single ☐ Couple ☐ Family	
Health Care	$2,500 prescription drug maximum.	$
Dental Coverage (optional)	☐ Single ☐ Couple ☐ Family	$
Total Premium (add all choices)		$
ARM Prestige 750	☐ Single ☐ Couple ☐ Family	
Health Care	$750 prescription drug maximum.	$
Dental Coverage (optional)	☐ Single ☐ Couple ☐ Family	$
Total Premium (add all choices)		$
ARM Dental Coverage Only	☐ Single ☐ Couple ☐ Family	$

Section D | Authorization & Payment Method (Select **ONE** payment method only and sign accordingly.)

I hereby apply for benefits coverage ("Coverage") and certify that the information provided is true and complete. I authorize OTIP and its Insurer to collect, use, maintain and disclose my personal information, including personal health information ("Information"), relevant to this application, for the purposes of evaluating my eligibility to the plan, benefits plan administration, providing me with ongoing services, protecting us both from error and fraud and complying with various legal requirements ("Purposes"). I am authorized to consent to the collection, use, maintenance and disclosure of Information pertaining to my Dependant(s) (spouse/child), if applicable, for the Purposes. I agree that the Information in this application will be shared with the Insurer and any Coverage shall not become effective until approved by the Insurer. I agree that my Coverage may be denied or terminated at any time as a result of any false, incomplete, or misleading information having been provided in support of this application. This authorization shall remain valid unless cancelled by me in writing.

☐ **METHOD A – Automatic monthly pension deduction for members who have a pension with Ontario Teachers' Pension Plan**

I hereby apply for coverage under the Active Retired Members health plan with OTIP and direct the Ontario Teachers' Pension Plan Board to deduct and remit premiums from my pension for my contribution towards the cost of this benefit contract. I understand and accept that premium amounts are subject to changes I elect and/or upon the renewal of my benefit contract and that OTIP will automatically apply and deduct the new premium amount from my pension and I agree to waive any other notice of premium changes. If my payment is rejected for any reason, I understand I will be notified and any outstanding amounts will be automatically deducted from my pension the following month. I consent to the collection, use and disclosure of any information required to administer the program including personal information such as my social insurance number (SIN).

SIN _____ **Signature** X _____ **Date (mm/dd/yy)** _____

OR

☐ **METHOD B – Monthly pre-authorized payment plan (PAD)**

I (the "payor") hereby authorize OTIP to withdraw monthly premium payments from my account on or about the first day of each month as well as any revised payment amounts or any other amounts that may be due and owing by me. If my payment is returned by my financial institution, for any reason, not limited to non-sufficient funds, I understand that an administrative fee for each payment returned may be added to the outstanding balance owed. If my payment is returned or stopped, I understand I will be notified and any outstanding amounts will be automatically withdrawn from my account the following month. OTIP may terminate coverage should a withdrawal be refused for any reason and the financial institution shall in no way be held liable should such an event occur. I understand and accept that premium amounts are subject to changes I elect and/or upon the renewal of my benefit contract and that OTIP will automatically apply and deduct the new premium amount from my account and I agree to waive any other notice of premium changes. This authorization shall remain valid unless canceled by me in writing, subject to providing notice of ten (10) business days prior to the next deduction from my account. I understand that cancellation of this authorization does not relieve me of my obligation to pay all amounts that may be owing to OTIP by a method that is satisfactory to OTIP.

I have certain recourse rights if any debit does not comply with this agreement. For example, I have the right to receive reimbursement for any debit that is not authorized or is not consistent with this pre-authorized debit agreement. To obtain more information about my recourse rights, I may contact my financial institution or visit www.cdnpay.ca. I warrant OTIP on a continuing basis that all persons authorized to sign on this Personal PAD account have authorized this agreement, agreed to all terms therein, and that the information provided with regard to this Personal PAD Account are accurate and complete. I undertake to notify OTIP of any changes to my chequing/savings account information, including change of name, at least ten (10) business days prior to the next Personal PAD from my account.

Type of Account: ☐ Chequing ☐ Savings **A void cheque MUST be attached to/included with this application.**

Is this a joint account requiring only one signature? ☐ Yes ☐ No **If both signatures are required, both account holders must sign this form.**

Signature X _____ X _____ **Date (mm/dd/yy)** _____