

ARM Application Form

Please return to:

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

Phone: 1-800-267-6847
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) mm dd yy	Applicant's Last Name	First Name	Middle Initial
Address	Apt.	Gender	
City/Town	Province		Postal Code
Home Telephone No.	Alternate Telephone No.	Email Address	
I prefer all correspondence in: <input type="radio"/> English <input type="radio"/> French			

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

Coordination of Benefits (COB) <input type="radio"/> yes Are you, your spouse or dependants covered under any other plan? <input type="radio"/> no	Name of other insurance company	Policy/Group No	ID/Certificate No
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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, please complete the policy information box, indicated by the yellow arrow.*

<input type="radio"/> I have been insured as an active member under a group health benefits plan.	▶ Plan Termination Date: mm dd yy
<input type="radio"/> I have been insured as a retired member under a group health benefits plan.	▶ Plan Termination Date: mm dd yy
<input type="radio"/> My current health plan is not terminating and I am looking to coordinate my benefits.	▶ Please call OTIP or visit www.otip.com/forms and download the Evidence of Insurability form.

Policy/Group No:	Identification/Certificate No:
Insurance Company Name:	
<input type="radio"/> 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 Evidence of Insurability form.

If you wish to receive emails about OTIP's products, services or promotions, please check here.

Section C Coverage Selection (Please select your options below and fill in the appropriate information.)		Monthly Premium
ARM Original 4000	<input type="radio"/> Single <input type="radio"/> Couple <input type="radio"/> Family	
Health Care	\$4,000 prescription drug and diabetic supplies max.	\$
Dental Coverage (Optional)	<input type="radio"/> Single <input type="radio"/> Couple <input type="radio"/> Family	\$
Total Premium (add all choices)		\$
ARM Prestige 2500	<input type="radio"/> Single <input type="radio"/> Couple <input type="radio"/> Family	
Health Care	<input type="radio"/> \$2,500 prescription drug and diabetic supplies max.	\$
Dental Coverage (Optional)	<input type="radio"/> Single <input type="radio"/> Couple <input type="radio"/> Family	\$
Total Premium (add all choices)		\$
ARM Prestige 750	<input type="radio"/> Single <input type="radio"/> Couple <input type="radio"/> Family	
Health Care	<input type="radio"/> \$750 prescription drug and diabetic supplies max.	\$
Dental Coverage (Optional)	<input type="radio"/> Single <input type="radio"/> Couple <input type="radio"/> Family	\$
Total Premium (add all choices)		\$
ARM Dental Coverage Only	<input type="radio"/> Single <input type="radio"/> Couple <input type="radio"/> Family	\$

Section D | Authorization & Payment Method (Please select ONE payment method 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 those in receipt of a pension from the Ontario Teachers' Pension Plan Board

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 # X _____ **Signature** X _____ Date _____

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 cancelled 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: Savings | Chequing

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 of Account Holder(s): X _____ X _____ Date _____