Ontario Principals' Council Est. 1998 | Benefits

GROUP BENEFITS APPLICATION

General Information

Surname | First Name | Initial

Birthdate (YYYY/MM/DD) ____________________ OPC Member No.____________________

Gender Identity: ❒ Male ❒ Female ❒ Non-binary ❒ Prefer not to specify ❒ Prefer to specify: _____________________

Address | City | Province

Postal Code | Phone No. ( ) | Personal Email

Employment Information

School Board | Employee No.

Position | Affiliation ❒ Elementary ❒ Secondary ❒ Other

Date of Appointment (YYYY/MM/DD) | Annual Salary $ | Pay Schedule ❒ 10 month ❒ 12 month

Work Email

Long Term Disability (LTD)

Coverage

❒ Option 1 – 100 calendar day qualifying period, terminates when eligible for a 70% unreduced pension (after 35 years of qualifying service).

❒ Option 2 – 150 calendar day qualifying period, terminates when eligible for a 70% unreduced pension (after 35 years of qualifying service).

❒ Option 3 – 100 calendar day qualifying period, terminates when you attain the 85 factor.

❒ Option 4 – 150 calendar day qualifying period, terminates when you attain the 85 factor.

❒ Option 5 – 100 calendar day qualifying period, terminates when eligible for a 70% unreduced pension (after 35 years of qualifying service). **PLUS,** COLA of 3% after 12 months of paid benefits.

❒ I confirm that I have read my T&C and LTD coverage is not mandatory at my board; and I do not want LTD coverage.

Note that it is your responsibility to advise the OPC when you have attained your 85 factor or become eligible for a 70% unreduced pension as you will not be eligible for LTD benefits/coverage after that date. Your coverage will not be automatically terminated on your pension eligibility date; YOU MUST NOTIFY OPC BENEFITS IN WRITING.

- I am a newly appointed administrator and applying within 60 calendar days of appointment: ❒ Yes ❒ No
- I am applying as a late applicant (after 60 days of appointment) * ❒ Yes ❒ No

***If you are applying for coverage as a late applicant (i.e., after 60 days of your initial appointment to administrator), or if your application was received after 60 days, you must complete the OTIP proof of good health form. The effective date of coverage will be the date the application is approved by OTIP.**

Authorization

By enrolling in this plan, I authorize and acknowledge that the OPC, as sponsor and administrator of the plan, will receive disclosure from me and/or from OTIP/RAEO Benefits Incorporated, the Trustees of the Ontario Teachers Insurance Plan (collectively "OTIP"), the group benefits insurance carrier ("Insurer") and their service providers, of any and all of the personal and /or health and medical information provided by me and/or my healthcare provider(s), the Insurer, and/or their service providers in support of my application for coverage and/or any claim I may make for benefits. All information received shall be used and/or disclosed for the purposes of enrollment, plan administration, enabling access to and provision of services, audit and assessment, investigation, and management of claims ("Purposes"), and shall be treated as confidential.

Applicant Signature: ______________________________________**Date:** ______________________________

Optional coverage on this page is in addition to any that you may have under the P/VP benefits trust (ONE-T) or privately. Check the "I do not want" box for each coverage option if you do not wish to apply for additional coverage.

Term Accidental Death and Dismemberment Coverage

Family Status Selected: ❐ Member Only ❐ Family Coverage ❐ I do not want Accidental Death and Dismemberment

Amount of Coverage Selected

❐ $ 25,000 ❐ $100,000 ❐ $175,000
❐ $ 50,000 ❐ $125,000 ❐ $200,000
❐ $ 75,000 ❐ $150,000

Beneficiary Surname	First Name	Initial	%	Relationship to Member

If you have named a beneficiary under the age of 18, please indicate the name of the Trustee. Insurance cannot be paid to an underage beneficiary. All proceeds will be directed to the appointed legal guardian or trustee. For underage beneficiaries to be protected, ensure that a legal guardian or trustee has been appointed through your Will.

Trustee (full name):

Optional Term Life Insurance

Member

Choose one coverage option:

❐ $ 25,000 ❐ $200,000
❐ $ 50,000 ❐ $250,000
❐ $100,000 ❐ $300,000
❐ $150,000 ❐ I do not want Optional Life Insurance

Have you smoked (e.g. cigarettes, cigars, pipe, etc.) or used e-cigarettes, vaporizers, tobacco in any form, or any smoking cessation aids within the last 12 months?

❐ Yes, Smoker Rates Apply
❐ No, Non-Smoker Rates Apply

Beneficiary Surname	First Name	Initial	%	Relationship to Member

For residents of Quebec, a spousal beneficiary is irrevocable unless you make the designation revocable by checking this box: ❐ Revocable

If you have named a beneficiary under the age of 18, please indicate the name of the Trustee. Insurance cannot be paid to an underage beneficiary. All proceeds will be directed to the appointed legal guardian or trustee. For underage beneficiaries to be protected, ensure that a legal guardian or trustee has been appointed through your will.

Trustee (full name): ____

Spousal Optional Term Life Insurance

Spouse

Please note you must have selected Optional Life Insurance for yourself above to elect this coverage.

Choose one coverage option:

❐ $ 25,000 ❐ $200,000
❐ $ 50,000 ❐ $250,000
❐ $100,000 ❐ $300,000
❐ $150,000 ❐ I do not want Spousal Life Insurance

Have you smoked (e.g. cigarettes, cigars, pipe, etc.) or used e-cigarettes, vaporizers, tobacco in any form, or any smoking cessation aids within the last 12 months?

❐ Yes, Smoker Rates Apply
❐ No, Non-Smoker Rates Apply

Child Optional Term Life Insurance

Children

Please note you must have selected Optional Life Insurance for yourself to elect this coverage.

Choose one coverage option:

❐ $ 5,000 per Child ❐ $20,000 per Child
❐ $10,000 per Child ❐ $25,000 per Child
❐ $15,000 per Child ❐ $30,000 per Child
❐ I do not want Life Insurance for Dependent Children

Note: Amounts for Term Member and Spousal Optional Life Insurance above $100,000 require the completion of the Evidence of Insurability form. The Member is automatically the beneficiary for Spousal and Child Life Insurance. Evidence of insurability is required for applications received after 60 days.

It is important that the applicant's smoking status be reported correctly. Misrepresentation may invalidate any claim that is made. Should your smoking status change, you must contact OPC Benefits at 1-800-701-2362 or opcbenefits@principals.ca.

Spousal Information (If applying for Spousal Optional Term Life Insurance and/or Term Accidental Death and Dismemberment {family} coverage)		
Surname	First Name	Initial
Birth Date (YYYY/MM/DD)		

Dependent Information (If applying for Child Optional Term Life Insurance and/or Term Accidental Death and Dismemberment {family coverage})	
Dependent Name (Surname, First Name)	Date of Birth (YYYY/MM/DD)

- Spousal information must be added if you are applying for Spousal Life Insurance and/or Accidental Death & Dismemberment (Family Coverage).
- Dependent information must be added if you are applying for Child Life Insurance and/or Accidental Death & Dismemberment (Family Coverage).

PLEASE READ THIS SECTION, SIGN AND DATE

PRIVACY STATEMENT:

Beginning January 1, 2004, the Personal Information Protection and Electronic Documents Act (PIPEDA) applies to personal information held by the Insurer. To ensure the confidentiality of the personal information held concerning you, OPC Benefits Administrator will establish an insurance file in which the information concerning your application for insurance will be placed, as well as information concerning any insurance claims. Only organizations and persons responsible for underwriting, administration, management, provision of services, investigation and claims, or any other person you authorize, will have access to this file, and if applicable, to have it rectified by submitting a written request to the address below.

AGREEMENT:

I understand that the insurance/coverage applied for shall become effective on the date specified by the Insurer, only if this application is accepted and the first premium is paid. I hereby certify that the foregoing answers and statements are true and complete to the best of my knowledge and belief. I hereby apply for coverage under the OPC Benefits Plan and authorize my employer to deduct the required premium from my pay, as applicable. If premiums are to be collected by bank withdrawal, I authorize the monthly withdrawal and remittance of premiums from my bank / trust company / credit union account for my contribution toward the cost of these benefits. The initial withdrawal may include retroactive premiums. If more than one signature is required on my joint account, all account holders must sign below. I consent to the disclosure of any information required to administer, manage, and service the Plan.

I authorize my employer____ to release information regarding my employment status including attendance records, salary information and job description to the OPC, to allow for the administration of the Plan including accurate calculation of premiums.

Applicant Signature: ____ Date: ___________________

Signature of **account/joint account holder**:____________________________________ Date: ___________________
(Other than the applicant AND if required for joint account)

Physical or electronic signature only

RETURN ALL COMPLETED FORMS TO:

OPC Benefits
2700-20 Queen St. W., P. O. Box 7
Toronto, Ontario M5H 3R3

Fax: 1-866-445-9249
Email: opcbenefits@principals.ca
Telephone: 416-322-6600 or 1-800-701-2362

INCLUDE YOUR CHEQUE / PRE-AUTHORIZED TRANSACTION FORM MARKED "VOID".
(where applicable)