



À votre service...pour le soin de votre avenir.

THE RETIRED TEACHERS OF ONTARIO

LES ENSEIGNANTES ET ENSEIGNANTS
RETRAITÉS DE L'ONTARIO

Here for you now ... Here for your future.

To enroll in the Group Insurance Benefits, you must be a member of RTO/ERO. If you are not a member, please complete a membership application and submit it with this form.

FOR OFFICE USE ONLY Certificate #

/ /

2012 Application for Group Insurance Benefits

Personal Information (Please print all information)

LAST NAME (as it appears on your Provincial Health Card)

FIRST NAME (as it appears on your Provincial Health Card)

GENDER

Male

Female

ADDRESS - STREET/BOX/R.R.

APT. NO.

CITY

PROVINCE

POSTAL CODE

TELEPHONE

E-MAIL

DATE OF BIRTH

DAY

MONTH

YEAR

SOCIAL INSURANCE NUMBER

PROVINCIAL HEALTH CARD NUMBER

NAME OF SCHOOL BOARD AT RETIREMENT (OR NAME OF EMPLOYER, IF OTHER THAN A SCHOOL BOARD)

DATE OF RETIREMENT

DAY

MONTH

YEAR

COMMENCEMENT OF ONTARIO TEACHERS' PENSION

DAY

MONTH

YEAR

Please indicate your status by checking the appropriate box:

A retired teacher/educator The surviving spouse/partner of an RTO/ERO member

Other retired school board employee Other (specify) _____

Took a commuted or deferred pension (Please attach a "VOID" cheque)

Not in receipt of an Ontario Teachers' Pension (Please attach a "VOID" cheque)

CURRENT INSURANCE INFORMATION

PLAN NAME

POLICY NUMBER

IDENTIFICATION NUMBER

DENTAL PLAN

Single Couple Family

EXTENDED HEALTH CARE PLAN

Single Couple Family

SEMI-PRIVATE HOSPITAL PLAN

Single Couple Family

TERMINATION DATE

DAY

MONTH

YEAR

TERMINATION DATE

DAY

MONTH

YEAR

TERMINATION DATE

DAY

MONTH

YEAR

I WISH TO ENROLL IN THE FOLLOWING BENEFITS:

DENTAL PLAN

Yes No

If yes: Single Couple Family

EXTENDED HEALTH CARE PLAN

Yes No

If yes: Single Couple Family

SEMI-PRIVATE HOSPITAL PLAN

Yes No

If yes: Single Couple Family

Your coverage will be effective the day after the termination of your previous coverage.

Please complete and sign the other side of this form >>>>

If you have selected couple or family coverage, please complete the following:

RELATIONSHIP TO PARTICIPANT

| SPOUSE/PARTNER | | | | |
|----------------|-----------|--|----------------|--------------------|
| FIRST NAME | LAST NAME | GENDER | DATE OF BIRTH | HEALTH CARD NUMBER |
| | | <input type="checkbox"/> M <input type="checkbox"/> F | DAY MONTH YEAR | |

OCCUPATION:

| DEPENDENTS | | | | |
|--|-----------|--|------------------------------|--------------------|
| FIRST NAME | LAST NAME | GENDER | DATE OF BIRTH | HEALTH CARD NUMBER |
| | | <input type="checkbox"/> M <input type="checkbox"/> F | DAY MONTH YEAR | |
| IF OVER 21 INDICATE: <input type="checkbox"/> STUDENT <input type="checkbox"/> FUNCTIONALLY DISABLED | | | RELATIONSHIP TO PARTICIPANT: | |
| | | <input type="checkbox"/> M <input type="checkbox"/> F | DAY MONTH YEAR | |
| IF OVER 21 INDICATE: <input type="checkbox"/> STUDENT <input type="checkbox"/> FUNCTIONALLY DISABLED | | | RELATIONSHIP TO PARTICIPANT: | |
| | | <input type="checkbox"/> M <input type="checkbox"/> F | DAY MONTH YEAR | |
| IF OVER 21 INDICATE: <input type="checkbox"/> STUDENT <input type="checkbox"/> FUNCTIONALLY DISABLED | | | RELATIONSHIP TO PARTICIPANT: | |
| | | <input type="checkbox"/> M <input type="checkbox"/> F | DAY MONTH YEAR | |
| IF OVER 21 INDICATE: <input type="checkbox"/> STUDENT <input type="checkbox"/> FUNCTIONALLY DISABLED | | | RELATIONSHIP TO PARTICIPANT: | |

IF CHILD(REN) OVER 21 AND A STUDENT, NAME OF SCHOOL(S):

CO-ORDINATION OF BENEFITS

Co-ordination of Benefits may allow you to obtain a reimbursement of up to 100% of your eligible expenses. If you or any other member of your family is entitled to medical benefits under any other plan, please provide:

| | | | |
|-------------------------------|----------------|---|--|
| NAME OF FAMILY MEMBER INSURED | DATE OF BIRTH | COVERAGE | TYPE OF COVERAGE |
| | DAY MONTH YEAR | <input type="checkbox"/> Single <input type="checkbox"/> Couple <input type="checkbox"/> Family | <input type="checkbox"/> Health only <input type="checkbox"/> Dental only <input type="checkbox"/> Health and Dental |
| NAME OF INSURER | POLICY NUMBER | IDENTIFICATION NUMBER | |
| | | | |

- I understand that I must be a member of RTO/ERO in order to enroll in the RTO/ERO Group Insurance Benefits.
- I hereby apply for coverage under the RTO/ERO Group Insurance Benefits Program and authorize the deduction and remittance of premiums from my Ontario Teachers' Pension Plan (OTPP) pension and/or bank account (where applicable) for my contribution towards the cost of these benefit contracts.
- I acknowledge that the RTO/ERO Group Insurance Benefits Booklet and RTO/ERO Master Policies will contain or have attached a Privacy Statement outlining how my personal and other information may be collected, used and disclosed in connection with the administration of the RTO/ERO Group Insurance Benefits Program and RTO/ERO Master Policies, claims thereunder and other stated purposes among Johnson Inc. (Agent, Administrator and Claims Payor), the Insurer(s), the Travel Assistance Provider, RTO/ERO and any other applicable parties.
- I consent to the collection, use and disclosure of any information required to administer the program as outlined in the Privacy Statement.
- I authorize the use of my Social Insurance Number for tax reporting and identification purposes.
- I hereby certify that I have completed this application so that all statements made herein are true and correct in all respects and may be relied upon by RTO/ERO without further inquiry.

| | |
|-----------------------------|----------------|
| SIGNATURE OF MEMBER | DAY MONTH YEAR |
| | |
| SIGNATURE OF SPOUSE/PARTNER | DAY MONTH YEAR |
| | |

PLEASE RETURN IN THE ENCLOSED ENVELOPE, WITH YOUR RTO/ERO MEMBERSHIP APPLICATION OR SEPARATELY, TO:

RTO/ERO, 18 Spadina Rd., Suite 300, Toronto ON M5R 2S7 • 416.962.9463 • 1.800.361.9888 • www.rto-ero.org • info@rto-ero.org

This application is available on our website at: www.rto-ero.org