REMINDER: TO ENROLL IN THE GROUP INSURANCE PLANS, 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.

Depuis 1968 RTO ERO Since 1968

2018 RTO/ERO
GROUP INSURANCE PLANS Application

DO NOT FILL IN; FOR OFFICE USE ONLY ____ / ____ / ____

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 ☐ Female ☐ Male

Address – Street/Box/R.R.:

Apt #: | City: | Province: | Postal code:

Home phone: | Mobile phone: | Email:

Date of birth: | DD | MM | YYYY | Social insurance number:

Provincial health card number:

Name of school board/employer (if not a school board) at retirement:

Date of retirement: | DD | MM | YYYY |

Start date of Ontario Teachers' Pension Plan (OTPP) if applicable: | DD | MM | YYYY |

Premiums to be deducted from:
- ☐ My Ontario Teachers' Pension Plan (OTPP)
- ☐ My bank account, if not in receipt of a pension from the OTPP (please attach a "VOID" cheque)
- ☐ I took a commuted or deferred pension (please attach a "VOID" cheque)

Please indicate your status:
- ☐ A retired education employee (specify position) _____
- ☐ The surviving spouse/partner of an RTO/ERO member

CURRENT/PREVIOUS INSURANCE INFORMATION:

- ☐ I am the plan member
- ☐ My spouse is the plan member (If you are currently insured under your spouse's plan, please enclose proof of coverage.)

Name of insurance company

Policy number | Identification number

DENTAL PLAN	EXTENDED HEALTH CARE PLAN	SEMI-PRIVATE HOSPITAL*
☐ Single ☐ Couple ☐ Family	☐ Single ☐ Couple ☐ Family	☐ Single ☐ Couple ☐ Family
Termination date | DD | MM | YYYY |	Termination date | DD | MM | YYYY |	Termination date | DD | MM | YYYY |

***Semi-private hospital coverage may be included in your school board extended health care plan. If so, please indicate this above.**

I WISH TO ENROLL IN THE FOLLOWING BENEFITS:

DENTAL PLAN	EXTENDED HEALTH CARE PLAN	SEMI-PRIVATE HOSPITAL & CONVALESCENT CARE PLAN
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If yes: ☐ Single ☐ Couple ☐ Family	If yes: ☐ Single ☐ Couple ☐ Family	If yes: ☐ Single ☐ Couple ☐ Family

YOUR COVERAGE WILL BE EFFECTIVE THE DAY **AFTER** THE TERMINATION OF YOUR PREVIOUS COVERAGE IF YOU APPLY WITHIN 60 DAYS OF THE TERMINATION DATE.

GROUP INSURANCE PLANS

Extended Health Care, Dental, Semi-Private Hospital and Convalescent Care are insured by Sun Life Assurance Company of Canada, a member of the Sun Life Financial group of companies, under a group insurance policy bearing contract numbers 141000, 141001, 141002, 141003.

Trip Cancellation, Interruption/Delay Benefits are underwritten by CUMIS General Insurance Company and administered by Allianz Global Assistance, under a group insurance policy bearing contract number FC310039. Allianz Global Assistance is a registered business name of AZGA Service Canada Inc. and AZGA Insurance Agency Canada Ltd. Each insurer is legally and financially responsible only for the payment of the benefits, which they each insure.

References to the "Insurers" in the Privacy Statement, set out on the next page, are to both Sun Life Assurance Company of Canada and CUMIS General Insurance Company.

PLEASE COMPLETE AND SIGN THE OTHER SIDE OF THIS FORM

IF YOU HAVE SELECTED COUPLE OR FAMILY COVERAGE, PLEASE COMPLETE THE FOLLOWING:

SPOUSE/PARTNER:

Last name: | First name:

Gender ☐ F ☐ M | Date of birth | DD | MM | YYYY | Health card number

Occupation:

DEPENDENTS:

Last name:	Last name:
First name:	First name:
Gender ☐ F ☐ M | Date of birth | DD | MM | YYYY |	Gender ☐ F ☐ M | Date of birth | DD | MM | YYYY |
Health card number	Health card number
If over 21 indicate: ☐ Student ☐ Functionally disabled If student, name of school:	If over 21 indicate: ☐ Student ☐ Functionally disabled If student, name of school:
Relationship to participant:	Relationship to participant:

COORDINATION OF BENEFITS

Coordination 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 | DD | MM | YYYY |

Name of insurance company

Policy number(s) | Identification number

Coverage
- ☐ Single
- ☐ Couple
- ☐ Family

Type of coverage
- ☐ Health
- ☐ Dental
- ☐ Semi-Private Hospital

☐ Please allow my spouse to contact Johnson Inc. to obtain any information regarding this insurance. I agree to allow Johnson Inc. to release and discuss any and all aspects as it pertains to our insurance. Spouse's name:

☐ I would like to have my dental, extended health care and/or convalescent care claim payments deposited directly into my bank account. If you choose this option, please attach a void cheque. If you have provided an email address, you will receive email notifications when your claim payments are deposited.

- **I understand that I must be a member of RTO/ERO to maintain the RTO/ERO Group Insurance Plans.**
- I hereby apply for coverage under the RTO/ERO Group Insurance Plans and authorize the deduction and remittance of premiums from my Ontario Teachers' Pension Plan (OTPP) pension (where applicable) and/or bank account for my contribution towards the cost of these benefit contracts. If deducting from my bank account, I have attached a VOID cheque. Premium is deducted one month in advance of the month of coverage.
- I acknowledge that in accordance with the below Privacy Statement, my personal information may be collected, used and disclosed in connection with the administration of the RTO/ERO Group Insurance Plans 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 authorize Johnson Inc. and/or RTO/ERO to use my Social Insurance Number for tax reporting and identification purposes. I also authorize Johnson Inc. and/or RTO/ERO to use my provincial health card number for plan eligibility 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: | Date: | DD | MM | YYYY |

Signature of spouse/partner (if applicable): | Date: | DD | MM | YYYY |

PRIVACY STATEMENT

I am authorized to disclose information about my spouse/partner and dependents for the purposes of determining their eligibility for coverage and enrolling them in RTO/ERO Group Insurance Benefits, including the related referral services. I authorize Johnson Inc. (Administrator and Claims Payor), the Insurers, Best Doctors, the Eldercare Select Provider (First Health Care), the Travel Assistance Provider (Allianz Global Assistance), as well as their agents and service providers, to collect, use and disclose relevant information about me, my spouse/partner and dependents needed for the purposes of enrolment, underwriting, adjudicating claims and the ongoing administration of the RTO/ERO Group Insurance Benefits and RTO/ERO Master Policies, including the related referral services, with each other, RTO/ERO and any other applicable parties.

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

RTO/ERO, 300 – 18 Spadina Road, Toronto ON M5R 2S7 • 416-962-9463 • 1-800-361-9888 • www.rto-ero.org • healthbenefits@rto-ero.org

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

Please mail the original application. Faxed, scanned or photocopied applications can not be accepted.