Depuis 1968 RTO ERO Since 1968

2016 Application for **Group Insurance Plans**

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.

DO NOT FILL IN; FOR OFFICE USE ONLY / /

Personal information (Please print all information)

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

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

GENDER
- ☐ Female
- ☐ Male

APT./UNIT NO.

ADDRESS - STREET/BOX/R.R.

CITY

PROVINCE

POSTAL CODE

HOME PHONE – –

MOBILE PHONE – –

EMAIL

DATE OF BIRTH DAY MONTH YEAR

SOCIAL INSURANCE NUMBER

PROVINCIAL HEALTH CARD NUMBER

NAME OF SCHOOL BOARD/EMPLOYER (IF NOT A SCHOOL BOARD) AT RETIREMENT

DATE OF RETIREMENT DAY MONTH YEAR

COMMENCEMENT OF ONTARIO TEACHERS' PENSION PLAN (OTPP) IF APPLICABLE DAY MONTH YEAR

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)
- ☐ 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 INSURER

POLICY NUMBER

IDENTIFICATION NUMBER

DENTAL PLAN
☐ Single ☐ Couple ☐ Family
TERMINATION DATE DAY MONTH YEAR

EXTENDED HEALTH CARE PLAN
☐ Single ☐ Couple ☐ Family
TERMINATION DATE DAY MONTH YEAR

SEMI-PRIVATE HOSPITAL PLAN*
☐ Single ☐ Couple ☐ Family
TERMINATION DATE DAY MONTH YEAR

*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
☐ Yes ☐ No
If yes: ☐ Single ☐ Couple ☐ Family

EXTENDED HEALTH CARE PLAN
☐ Yes ☐ No
If yes: ☐ Single ☐ Couple ☐ Family

SEMI-PRIVATE HOSPITAL & CONVALESCENT CARE 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
		☐ F ☐ M	DAY MONTH YEAR	

OCCUPATION:

DEPENDENTS

FIRST NAME	LAST NAME	GENDER	DATE OF BIRTH DAY MONTH YEAR	HEALTH CARD NUMBER
		☐ F ☐ M		
IF OVER 21 INDICATE: ☐ STUDENT ☐ FUNCTIONALLY DISABLED			RELATIONSHIP TO PARTICIPANT:	
		☐ F ☐ M		
IF OVER 21 INDICATE: ☐ STUDENT ☐ 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 DAY MONTH YEAR	COVERAGE	TYPE OF COVERAGE
		☐ Single ☐ Couple ☐ Family	☐ Health ☐ Dental ☐ Semi-Private Hospital

NAME OF INSURER	POLICY NUMBER(S)	IDENTIFICATION NUMBER

☐ 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.

☐ 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 Benefits.**
- I hereby apply for coverage under the RTO/ERO Group Insurance Benefits 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 the RTO/ERO Insurance Plans 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 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 (IF APPLICABLE)	DAY MONTH YEAR

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