Depuis 1968 RTO ERO Since 1968

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.

DO NOT FILL IN FOR OFFICE USE ONLY / /

2015 Application for Group Insurance Benefits

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 ☐ Male ☐ Female

APT./UNIT NO.

ADDRESS - STREET/BOX/R.R.

CITY

PROVINCE

POSTAL CODE

HOME PHONE – –

MOBILE PHONE – –

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 PLAN (OTPP) DAY MONTH YEAR

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

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)

CURRENT 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.)

PLAN NAME

INSURANCE COMPANY

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

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
		☐ M ☐ F	DAY MONTH YEAR	

OCCUPATION:

DEPENDENTS

FIRST NAME	LAST NAME	GENDER	DATE OF BIRTH DAY MONTH YEAR	HEALTH CARD NUMBER
		☐ M ☐ F		
IF OVER 21 INDICATE: ☐ STUDENT ☐ FUNCTIONALLY DISABLED			RELATIONSHIP TO PARTICIPANT:	
		☐ M ☐ F		
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

1. I would like to have my Dental and/or Extended Health Care claim payments deposited directly into my bank account: ☐ Yes ☐ No. If yes, please attach a void cheque. If you have provided an email address, you will receive email notifications when your claim payments are deposited.
2. **I understand that I must be a member of RTO/ERO to maintain the RTO/ERO Group Insurance Benefits.**
3. 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 and/or bank account (where applicable) for my contribution towards the cost of these benefit contracts. If deducting from my bank account, I have attached a VOID cheque.
4. 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.
5. I consent to the collection, use and disclosure of any information required to administer the program as outlined in the Privacy Statement.
6. I authorize the use of my Social Insurance Number for tax reporting and identification purposes.
7. 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, 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