



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 <input type="checkbox"/> Male <input type="checkbox"/> 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 <input type="checkbox"/> I am the plan member <input type="checkbox"/> 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 <input type="checkbox"/> Single <input type="checkbox"/> Couple <input type="checkbox"/> Family	EXTENDED HEALTH CARE PLAN <input type="checkbox"/> Single <input type="checkbox"/> Couple <input type="checkbox"/> Family	SEMI-PRIVATE HOSPITAL PLAN <input type="checkbox"/> Single <input type="checkbox"/> Couple <input type="checkbox"/> 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 <input type="checkbox"/> Yes <input type="checkbox"/> No If yes: <input type="checkbox"/> Single <input type="checkbox"/> Couple <input type="checkbox"/> Family	EXTENDED HEALTH CARE PLAN <input type="checkbox"/> Yes <input type="checkbox"/> No If yes: <input type="checkbox"/> Single <input type="checkbox"/> Couple <input type="checkbox"/> Family	SEMI-PRIVATE HOSPITAL & CONVALESCENT CARE PLAN <input type="checkbox"/> Yes <input type="checkbox"/> No If yes: <input type="checkbox"/> Single <input type="checkbox"/> Couple <input type="checkbox"/> 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:	
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 <input type="checkbox"/> Single <input type="checkbox"/> Couple <input type="checkbox"/> Family	TYPE OF COVERAGE <input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Semi-Private Hospital
NAME OF INSURER	POLICY NUMBER(S)	IDENTIFICATION NUMBER	

- 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.
- 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 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.
- 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, 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