Ontario Principals' Council | Benefits

TIME SENSITIVE – APPLY WITHIN 60 DAYS OF APPOINTMENT

GROUP BENEFIT APPLICATION CHECKLIST

Before returning your completed application, ensure that the following information has been completed/included:

- ❑ Group Benefit Application
  - Complete all sections of the form
  - Sign both pages 1 and 4 even if you are not applying for Accidental Death & Dismemberment (AD&D) or Life Insurance
  - Check the "I do not want" box for each optional insurance (AD&D, Member, Spousal, Child Optional Life Insurance) listed on page 2 if you are not applying for additional coverage
  - Fill in your appointment date (the first day of work in the role)
  - Fill in your current salary
  - Add your OPC number (you can still submit the application if the number is not yet assigned)
  - Ensure that any changes are legible and initialled
- ❑ Sign Information Release Authorization
- ❑ Sign Pre-Authorized Debit (PAD) Agreement and attach void cheque
- ❑ If you are in one of the school boards* listed below, your employee ID number is required instead of a PAD and void cheque
- ❑ Complete Evidence of Insurability - *applicable only to*
  - Applicants applying 60 days after the date of appointment
  - Applicants who were not previously enrolled in an LTD plan (up to the date of appointment)
  - Applicants applying for Optional or Spousal Life Insurance over $100,000
- ❑ If you need to make changes to the form, you must strike through and initial the change. Corrective liquid (e.g., "white-out") is not permitted
- ❑ Be sure to retain a copy of the documents for your records including a fax confirmation where necessary. We may request the originals if faxed/scanned copies are not legible
- ❑ Completed forms can be faxed, scanned/emailed using the details below

Note that you must be an OPC Member to enrol in the OPC Benefits Plan. Your application will be processed once all required documents are received. **Provided all criteria are met, you will be enrolled as of your date of appointment.**

Thank you for your attention to these details.

*Boards for which employee ID number is required: Algoma, Greater Essex, Halton, Hamilton-Wentworth, Grand Erie, Rainy River.

OPC Benefits: 416-322-6600; 1-800-701-2362. Fax 1-866-445-9249
www.principals.ca *opcbenefits@principals.ca*

Ontario Principals' Council | Benefits

GROUP BENEFIT APPLICATION FORM

General Information

Surname	First Name	Initial
Birthdate (YYYY/MM/DD)	Gender ❒ Female ❒ Male	Cert /OPC Member No.
Address	City	Province
Postal Code	Phone No. ( )	Personal Email

Employment Information

School Board		Employee No.
Position	Affiliation ❒ Elementary ❒ Secondary ❒ Other	
Date of Appointment (YYYY/MM/DD)	Annual Salary $	Pay Schedule ❒ 10 month ❒ 12 month
Work Email		

Long Term Disability (LTD)

Coverage

❒ Option 1 – 100 calendar day waiting period, terminates when eligible for a 70 per cent unreduced pension (after 35 years of qualifying service).

❒ Option 2 – 150 calendar day waiting period, terminates when eligible for a 70 per cent unreduced pension (after 35 years of qualifying service).

❒ Option 3 – 100 calendar day waiting period, terminates when you attain the 85 factor.

❒ Option 4 – 150 calendar day waiting period, terminates when you attain the 85 factor.

❒ Option 5 – 100 calendar day waiting period, terminates when eligible for a 70 per cent unreduced pension (after 35 years of qualifying service). **PLUS,** COLA of 3% after 12 months of paid benefit.

❒ I confirm that I have read my T&C and LTD coverage is not mandatory at my board; I do not want LTD coverage.

❒ I have LTD coverage under an Individual Policy insured by: Insurer: _____Policy #: _____

Note that it is your responsibility to advise the OPC when you have attained your 85 factor or become eligible for a 70 per cent unreduced pension as you will not be entitled to LTD benefits/coverage after that date. Your coverage <u>will not</u> be automatically terminated on your pension eligibility date; YOU MUST NOTIFY OPC BENEFITS IN WRITING.

- **If you are a newly appointed administrator and applying within 60 calendar days of appointment:**
  I had continuous LTD coverage up to my appointment date ❒ Yes ❒ No
- I am applying as a late applicant (after 60 days of appointment) * ❒ Yes ❒ No
- I did not have prior or continuous LTD coverage and wish to be enrolled with pre-existing conditions ** ❒ Yes ❒ No
- I currently have LTD coverage under a Group Policy and wish to switch to the OPC Plan *** ❒ Yes ❒ No

*** If you are applying for coverage as a late applicant i.e., after 60 days of your initial appointment to administrator, or if your application was received after 60 days, you must complete the evidence of insurability form. The effective date of coverage will be the date the application is approved by Canada Life.**

****The insurer will not pay claims for a disability related to pre-existing conditions within the first 12 months of enrolment. Evidence of insurability will not be required for enrolment.**

*****Proof of coverage and other LTD policy criteria must be met prior to approval of the switch.**

Authorization

By enrolling in this plan, I authorize and acknowledge that the OPC, as sponsor and administrator of the plan, will receive disclosure from me and/or from Canada Life, of any and all of the health and medical information provided by me and/or my healthcare provider(s) to Canada Life in support of my application for coverage and/or any claim I may make for benefits. All information received shall be used solely for the purpose of enrollment and plan administration and shall be treated as confidential.

Applicant Signature: _____ **Date:** _____

Optional coverage on this page is in addition to any that you may have through the Board (ONE-T) or privately. Check the "I do not want" box for each coverage option, if you do not wish to apply for additional coverage.

Term Accidental Death and Dismemberment Coverage

Family Status Selected ❒ Member Only ❒ Family Coverage ❒ I do not want Accidental Death and Dismemberment

Amount of Coverage Selected

❒ $200,000 ❒ $125,000 ❒ $ 50,000
❒ $175,000 ❒ $100,000 ❒ $ 25,000
❒ $150,000 ❒ $ 75,000

Beneficiary Surname	First Name	Initial	%	Relationship to Member

If you have named a beneficiary under age 18, please indicate the name of the Trustee. Insurance cannot be paid to an underage beneficiary. All proceeds will be directed to the appointed legal guardian or trustee. For underage beneficiaries to be protected, ensure that a legal guardian or trustee has been appointed through your Will.

Trustee:

Optional Term Life Insurance

Member

Choose one:

❒ $200,000 Coverage ❒ $ 50,000 Coverage
❒ $150,000 Coverage ❒ $ 25,000 Coverage
❒ $100,000 Coverage ❒ I do not want Optional Life Insurance

Have you smoked (cigarettes, cigars or pipes etc.) or used tobacco in any other form within the last 12 months?

❒ Yes, Smoker Rates Apply
❒ No, Non-Smoker Rates Apply

Beneficiary Designation for Member Coverage

Beneficiary Surname	First Name	Initial	%	Relationship to Member

For residents of Quebec, a spousal beneficiary is irrevocable unless you make the designation revocable by checking the box below:
❒ Revocable

If you have named a beneficiary under age 18, please indicate the name of the Trustee. Insurance cannot be paid to an underage beneficiary. All proceeds will be directed to the appointed legal guardian or trustee. For underage beneficiaries to be protected, ensure that a legal guardian or trustee has been appointed through your Will.

Trustee:

Spousal Optional Term Life Insurance

Spouse

Please note you must have selected Life Insurance for yourself to elect this coverage.

Choose one:

❒ $200,000 Coverage ❒ $ 50,000 Coverage
❒ $150,000 Coverage ❒ $ 25,000 Coverage
❒ $100,000 Coverage ❒ I do not want Spousal Life Insurance

Have you smoked (cigarettes, cigars or pipes etc.) or used tobacco in any other form within the last 12 months?

❒ Yes, Smoker Rates Apply
❒ No, Non-Smoker Rates Apply

Child Optional Term Life Insurance

Children

Please note you must have selected Life Insurance for yourself to elect this coverage.

Choose One:

❒ $20,000 Coverage per Child ❒ $10,000 Coverage per Child
❒ $15,000 Coverage per Child ❒ $ 5,000 Coverage per Child
❒ I do not want Life Insurance for Dependent Children

Note: Amounts for Term Member and Spousal Optional Life Insurance above $100,000 require the completion of the enclosed Evidence of Insurability form. The Member is automatically the beneficiary for Spousal and Child Life Insurance.

It is important that the applicant's smoking status be reported correctly. Misrepresentation may invalidate any claim that is made. Should your smoking status change in the future, you must contact OPC Benefits at 1-800-701-2362 or opcbenefits@principals.ca.

Spousal Information
(if applying for Spousal Optional Term Life Insurance and/or Term Accidental Death and Dismemberment {family} coverage)

Surname	First Name	Initial

Birth Date (YYYY/MM/DD)	Gender	❒ Female ❒ Male

Dependent Information
(if applying for Child Optional Term Life Insurance and/or Term Accidental Death and Dismemberment {family coverage})

Dependent Name (Surname, First Name)	Date of Birth (YYYY/MM/DD)	Gender
		❒ Female ❒ Male
		❒ Female ❒ Male
		❒ Female ❒ Male
		❒ Female ❒ Male
		❒ Female ❒ Male
		❒ Female ❒ Male
		❒ Female ❒ Male

PLEASE READ THIS SECTION, SIGN AND DATE

PRIVACY STATEMENT:

Beginning January 1, 2004, the Personal Information Protection and Electronic Documents Act (PIPEDA) will apply to personal information held by the insurance companies. To ensure the confidentiality of the personal information held concerning you, OPC Benefits Administrator and Canada Life will establish an insurance file in which the information concerning your application for insurance will be placed, as well as information concerning any insurance claims. Only employees or authorized organizations who will be responsible for underwriting, administration, investigation and claims, or any other person you authorize, will have access to this file, and if applicable, to have it rectified by submitting a written request to the address below.

AGREEMENT:

I understand that the insurance applied for shall become effective on the date specified by Canada Life, only if this application is accepted and the first premium is paid. I hereby certify that the foregoing answers and statements are true and complete to the best of my knowledge and belief. I hereby apply for coverage under the OPC Benefits Program and authorize my employer to deduct the required premium from my pay, as applicable. If premiums are to be collected by bank withdrawal, I authorize the monthly withdrawal and remittance of premiums from my bank / trust company / credit union account for my contribution toward the cost of these benefits. The initial withdrawal may cover up to three monthly premiums. If more than one signature is required on your joint account, all account holders must sign below. I consent to the disclosure of any information required to administer the Program. In the event of an LTD claim, I will notify the OPC of said claim.

I authorize my employer_____ to release information regarding my employment status including attendance records, salary information and job description to the OPC, to allow for the administration of the Program including accurate calculation of premiums.

Applicant Signature: _____ Date:_____

Signature of **account/joint account holder**:_____ Date:_____
(Other than the applicant AND if required for joint account)

Physical or electronic signature only

Return completed forms to:

OPC Benefits
2700-20 Queen St. W., P. O. Box 7
Toronto, ON, M5H 3R3
Fax: 1-866-445-9249
Email: opcbenefits@principals.ca

Telephone: 416-322-6600 or 1-800-701-2362

INCLUDE YOUR CHQUE/PRE-AUTHORIZED TRANSACTION FORM MARKED "VOID", where applicable

THE Great-West Life ASSURANCE COMPANY

EVIDENCE OF INSURABILITY

Coverage Detail

Ontario Principals' Council | Benefits

Instructions: Please print all answers and complete in INK only (blue or black)

Ensure that all required sections are completed. An incomplete form may result in a delay in processing.

Member

- Sections 1-2: To be completed, signed and dated by the Member, including completion of the smoking declaration.
- Sections 3-4: To be completed by the Member/spouse. Retain a copy of all pages for your files.
  Send to: Ontario Principals' Council.

Ontario Principals' Council

- Sections 1-3: To be reviewed and amended where necessary.
  Send the application to: Group Medical Underwriting, Great-West Life.

Section #1 Member's Information

Name of Group Policyholder	Policy No.	Cert. / OPC Member No.
ONTARIO PRINCIPALS' COUNCIL	**175360 (LTD)** **175361 (Optional Coverage)**	

Member Last Name	First Name	Middle Initial

Annual Earnings	School Board

Is the Member currently actively at work? ☐ Yes ☐ No

If no, please indicate reason and Expected Return to Work Date. MMM/DD/YYYY

☐ Maternity/Paternity ☐ On Claim / Personal LOA / Other

Section #2 Reason for Application

Section #2 (A) Long Term Disability

☐ Not currently covered for LTD or Late Applicant (after 60 day open enrolment)

☐ Wanting to change LTD Options **Current Coverage** _____ **Desired Coverage** _____

Section #2 (B) Term Life Insurance

Member ☐ New Applicant (applying after 60 day open enrolment or applying for coverage over $100,000)

☐ Increasing Life Coverage. **Current Coverage** _____ **Desired Coverage** _____

Spouse ☐ New Applicant (applying after 60 day open enrolment or applying for coverage over $100,000)

☐ Increasing Life Coverage **Current Coverage** _____ **Desired Coverage** _____

Dependent ☐ New Applicant (applying after 60 day open enrolment)

☐ Increasing Life Coverage. **Current Coverage** _____ **Desired Coverage** _____

Smoking Declaration

Within the past 12 months have you smoked or used cigarettes, e-cigarettes, cigarillos, pipe, cigars, nicotine patch and/or gum, chewing tobacco, hookah, or tobacco or nicotine products in any other form?

	YES	NO
MEMBER	☐	☐
SPOUSE	☐	☐

Plan Member's Signature

Signature	Date
	MMM/DD/YYYY

M5995(175360)-3/19

THE Great-West Life ASSURANCE COMPANY

EVIDENCE OF INSURABILITY

Applicant Information

Section #3 — Member and Dependant Details — *Completed by the Member*

Member Information

Name of Group Policyholder: **ONTARIO PRINCIPALS' COUNCIL**

Policy No.: **175360 (LTD)** **175361 (Optional Coverage)**

Member Last Name	First Name	Middle Initial	Gender
			☐ Male ☐ Undisclosed ☐ Female ☐ Other

Date of Birth	Occupation	Job Duties
MMM/DD/YYYY		

Home Mailing Address — Street	City	Province	Postal Code

Email Address

NOTE: If you provide your email address, we may use it to communicate with you about this application.

Home Phone Number	Best time to call	Alternate Contact Number	Extension	Best time to call
XXX-XXX-XXXX	☐ Day ☐ Evening	XXX-XXX-XXXX	XXXX	☐ Day ☐ Evening

Spouse Information (if applicable) - *only required if you are applying for dependant coverage.*

Spouse Last Name	First Name	Middle Initial	Gender
			☐ Male ☐ Undisclosed ☐ Female ☐ Other

Date of Birth	Occupation	Job Duties
MMM/DD/YYYY		

Email Address

NOTE: If you provide your email address, we may use it to communicate with you about this application.

Home Phone Number	Best time to call	Alternate Contact Number	Extension	Best time to call
XXX-XXX-XXXX	☐ Day ☐ Evening	XXX-XXX-XXXX	XXXX	☐ Day ☐ Evening

Child Information (if applicable) - *only required if you are applying for dependant coverage.*

	Child Last Name	Child First Name	Gender	Date of Birth
Child (1)			☐ Male ☐ Undisclosed ☐ Female ☐ Other	MMM/DD/YYYY
Child (2)			☐ Male ☐ Undisclosed ☐ Female ☐ Other	MMM/DD/YYYY
Child (3)			☐ Male ☐ Undisclosed ☐ Female ☐ Other	MMM/DD/YYYY
Child (4)			☐ Male ☐ Undisclosed ☐ Female ☐ Other	MMM/DD/YYYY

YOUR APPLICATION CANNOT BE PROCESSED IF ALL APPROPRIATE QUESTIONS ARE NOT ANSWERED

THE Great-West Life ASSURANCE COMPANY

EVIDENCE OF INSURABILITY

Medical & Lifestyle Questionnaire

YOU SHOULD NOT TELL US ABOUT ANY GENETIC TEST WHICH YOU MAY HAVE HAD DONE. YOU MUST HOWEVER, TELL US IF YOU ARE HAVING TREATMENT FOR, OR EXPERIENCING SYMPTOMS OF A GENETIC CONDITION.

Section #4 Personal Medical History and Lifestyle Information

Please provide details of any "Yes" answers in the space below. **If extra space is required, please complete Page 6 - Additional Details at the end of this document and provide the number of the question.**

MB = Member **SP** = Spouse **CH** = Child(ren)

1. Do you now have or have you ever had: cancer, heart disease, diabetes, arthritis, any neurological, psychiatric, intestinal or respiratory disorders, or any other chronic medical condition(s)?	Yes No MB ☐ ☐ SP ☐ ☐ CH ☐ ☐	Please describe medical condition, including the date of onset and duration.
2. Have you ever tested positive for hepatitis or HIV?	Yes No MB ☐ ☐ SP ☐ ☐ CH ☐ ☐	Please describe which test, why you had it and when.
3. Have you ever had an MRI or CT scan?	Yes No MB ☐ ☐ SP ☐ ☐ CH ☐ ☐	Please provide approximate year, describe for what reason(s) and the results.
4. Have you ever stayed overnight in a hospital?	Yes No MB ☐ ☐ SP ☐ ☐ CH ☐ ☐	Please provide approximate year, duration of stay and medical diagnosis.
5. Have you ever received workers' compensation or sickness disability benefits for more than 7 consecutive days?	Yes No MB ☐ ☐ SP ☐ ☐ CH ☐ ☐	Please provide the approximate date that you left work, duration off work and medical condition.
6. Have you ever missed more than 10 days from work or school for illness or injury other than that described in question 5?	Yes No MB ☐ ☐ SP ☐ ☐ CH ☐ ☐	Please provide date and describe the medical condition, if not already described above.
7. Have you ever had an application for insurance declined or modified?	Yes No MB ☐ ☐ SP ☐ ☐ CH ☐ ☐	Please provide approximate year and describe for what reason(s).
8. Do you have any reason to believe that you will require medical or surgical treatment during the next 12 months?	Yes No MB ☐ ☐ SP ☐ ☐ CH ☐ ☐	Please describe the reason.
9. In the last 12 months have you been taking any prescription medication?	Yes No MB ☐ ☐ SP ☐ ☐ CH ☐ ☐	Please provide name of medication, dosage, duration, and medical condition for which you are taking/took it.
10. Have you ever been advised to drink less alcohol by your physician, or used drugs (including marijuana) for non-medical reasons in the last 10 years?	Yes No MB ☐ ☐ SP ☐ ☐ CH ☐ ☐	Please provide details of when, which product used, and frequency of use per week.
11. Do you drink alcohol?	Yes No MB ☐ ☐ SP ☐ ☐ CH ☐ ☐	Please provide type of alcohol and quantity per week.
12. Within the past 12 months have you smoked or used cigarettes, e-cigarettes, cigarillos, pipe, cigars, nicotine patch and/or gum, chewing tobacco, hookah, or tobacco, or nicotine products in any other form?	Yes No MB ☐ ☐ SP ☐ ☐ CH ☐ ☐	Please provide which product you use, how much/many per day.

Section #4 Personal Medical History and Lifestyle Information ...continued

Please provide details of any "Yes" answers in the space below. **If extra space is required, please complete Page 6 - Additional Details at the end of this document and provide the number of the question.**

MB = Member **SP** = Spouse **CH** = Child(ren)

13. Have you gained or lost more than 10 pounds in the last 12 months?	Yes No MB ☐ ☐ SP ☐ ☐ CH ☐ ☐	Please specify weight loss or gain, amount of change in weight, and reason.
14. Current height and weight: MEMBER: _____ m/cm or _____ feet/inches _____ kg or _____ pounds SPOUSE: _____ m/cm or _____ feet/inches _____ kg or _____ pounds		
15. Do you have a regular healthcare provider? If yes, please advise (in section to the right) Provider's name, address and date and reason of last appointment.	Yes No MB ☐ ☐ SP ☐ ☐ CH ☐ ☐	
16. Have you been referred to any medical specialists in the last 2 years?	Yes No MB ☐ ☐ SP ☐ ☐ CH ☐ ☐	Please provide the name of specialist, type of specialty and medical reason for visit.
17. Do you, or are you planning to, participate in hazardous activities such as parachute jumping, hang-gliding, scuba diving, aviation or motorized racing?	Yes No MB ☐ ☐ SP ☐ ☐ CH ☐ ☐	Please describe the type and frequency of the activity.
18. Please describe weekly exercise including type of activity, duration and frequency.		

Family History

19. For each applicant, do your parents, siblings, spouse or children suffer or have suffered from any of the following:

- Alzheimer's Disease
- Amyotrophic lateral Sclerosis (ALS or Lou Gehrig's Disease)
- Cancer
- Cardiomyopathy
- Dementia
- Diabetes
- Heart Disease
- Huntington's chorea
- Motor Neuron disease
- Multiple Sclerosis
- Parkinson's Disease
- Polycystic Kidney disease
- Retinitis Pigmentosa
- Stroke
- and/or any other hereditary medical condition

Member: ☐ **Yes** ☐ **No** **Spouse:** ☐ **Yes** ☐ **No** **Children:** ☐ **Yes** ☐ **No**

If yes, please complete the appropriate section below. Use extra paper if required.

Member (Family Member/Relationship):	Gender	Age if living	Age at death if deceased	Approximate age at onset	Illness (including specific type, if known)
	☐ Male ☐ Female ☐ Undisclosed ☐ Other				
	☐ Male ☐ Female ☐ Undisclosed ☐ Other				

Spouse (Family Member/Relationship):	Gender	Age if living	Age at death if deceased	Approximate age at onset	Illness (including specific type, if known)
	☐ Male ☐ Female ☐ Undisclosed ☐ Other				
	☐ Male ☐ Female ☐ Undisclosed ☐ Other				

Children (Family Member/Relationship):	Gender	Age if living	Age at death if deceased	Approximate age at onset	Illness (including specific type, if known)
	☐ Male ☐ Female ☐ Undisclosed ☐ Other				
	☐ Male ☐ Female ☐ Undisclosed ☐ Other				

Please provide any additional information that you feel is important:

Notice About MIB Inc.

IMPORTANT NOTICE

Your personal information will be treated as confidential. Great-West Life or its reinsurer(s) may, however, make a brief report to the MIB Inc., a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members. If you apply to another bureau member company for life or health insurance or submit a claim for benefits to such a company, the bureau will upon request supply the company with the information it may have.

Great-West Life or its reinsurer(s) may also release information to other life insurance companies to whom you apply for life or health insurance, or to whom you submit a claim for benefits. The company will not, however, reveal to another company or to the bureau the action taken on the basis of your current request for insurance.

If you wish to see the information in your bureau file or have it corrected, please contact the bureau's information office at:

Suite 501, 330 University Avenue, Toronto ON M5G 1R7, Tel 416.597.0590

Protecting Your Personal Information

At **The Great-West Life Assurance Company**, we recognize and respect the importance of privacy. When you apply for coverage, we establish a confidential file that contains your personal information. This file is kept in the offices of Great-West Life or the offices of an organization authorized by Great-West Life. You may exercise certain rights of access and rectification with respect to the personal information in your file by sending a request in writing to Great-West Life. Great-West Life may use service providers located within or outside Canada. We limit access to personal information in your file to Great-West Life staff or persons authorized by Great-West Life who require it to perform their duties, to persons to whom you have granted access, and to persons authorized by law. Your personal information may be subject to disclosure to those authorized under applicable law within or outside Canada. We use the personal information for the purposes of determining your insurability and administering the group benefits plan. This includes investigating and assessing claims, and creating and maintaining records concerning our relationship. For a copy of our Privacy Guidelines, or if you have questions about our personal information policies and practices (including with respect to service providers), write to Great-West Life's Chief Compliance Officer or refer to www.greatwestlife.com.

Authorization and Declarations

I authorize:

- Great-West Life, any healthcare provider, my plan administrator, other insurance companies or reinsurance companies, the MIB Inc., administrators of government benefits or other benefits programs, other organizations, or service providers working with Great-West Life to exchange personal information, when necessary to determine my insurability and to administer the group benefits plan;
- Great-West Life to have performed tests, examinations, blood profiles and urinalysis tests as may be required to determine my insurability in connection with this application;
- Great-West Life to release my medical records to the regular healthcare provider or clinic named in this application including any test results that may be obtained during the application process;
- Great-West Life to communicate with me about this application using the email address I have provided;
- My plan sponsor to deduct from my pay and remit to Great-West Life the plan member contributions required under the plan, if applicable.

I certify or confirm that:

- I am actively at work on the date this application is signed;
- I have read and agree with the Important Notice describing the procedures of the MIB Inc.;
- I have retained a copy of this application;
- If applying for coverage for dependents, I am authorized to act on their behalf;
- A photocopy or an electronic copy of this authorization is as valid as the original.

The statements and answers on this form will be used to determine your insurability and to provide benefits under the plan. Any changes in the accuracy of any of the statements and answers on the form between the date this form is signed and the effective date of any coverage approved by Great-West Life must be reported to Great-West Life. I understand that if I fail to do so, any coverage granted may be void.

I declare that to the best of my knowledge, all of the above answers to the questions are complete and true. I understand that if any answer is incomplete or false, any coverage granted may be void. I understand that I may be refused for coverage for all or part of any benefit if, in the opinion of Great-West Life, I am not insurable for all or part of that benefit.

For Quebec Applicants: I request that all communication and documents be in English.
Je demande à ce que toutes les communications et tous les documents soient en anglais.

Member Signature _____ Date Signed _____ MMM/DD/YYYY

Spouse Signature _____ Date Signed _____ MMM/DD/YYYY

The Great-West Life Assurance Company
Group Medical Underwriting
PO Box 6000
Winnipeg MB R3C 3A5
Email: groupmed@gwl.ca
TTY Line 1.800.990.6654 (available for the deaf or hard of hearing)

Please return the completed form to the Ontario Principals' Council

Additional Details

This page is to be used if you require **extra space to respond to a question.**
Provide the number of the question you are addressing.

MB = Member **SP** = Spouse
CH = Child(ren)

Question #	Details

INFORMATION RELEASE AUTHORIZATION

I authorize my employer _____ to release information regarding my employment status including attendance records, salary information and job description to the OPC Benefits Administrator and Canada Life to allow them to administer the benefits program and properly calculate premiums under the plan.

I understand that this authorization may be revoked by written notice to OPC, but this will not apply to information already released. I know I may request a copy of this authorization. I also agree that a photocopy or facsimile of this authorization shall be as valid as the original.

PRIVACY STATEMENT:

Beginning January 1, 2004, the Personal Information Protection and Electronic Documents Act (PIPEDA) will apply to personal information held by the insurance companies. To ensure the confidentiality of the personal information held concerning you, OPC Benefits Administrator and /or Canada Life will establish an insurance file in which the information concerning your application for insurance will be placed, as well as the information concerning any insurance claims. Only employees or authorized organizations who will be responsible for underwriting, administration, investigation and claims, or any other person you authorize, will have access to this file.

Please Print Name _____ Signed _____

Employee Number _____ Date _____

PRE-AUTHORIZED DEBIT (PAD) AGREEMENT
BANK ACCOUNT CHANGE FORM

To initiate a pre-authorized debit agreement or to change the bank account used for your pre-authorized debit arrangements, complete this form and return to OPC Benefits.

Full Name (OPC Member): _____ OPC Number: _____

Account Information

Name and address of Financial Institution: _____

_____

Transit Number: _____ Bank Code: _____ Account Number: _____

Important note: You must attach a void cheque or pre-authorized transaction form from your financial institution for this authorization to be effective.

Your monthly withdrawals will be processed on/around the first business day of each month.

Terms and Conditions of this PAD Agreement

Authorization	I, the account holder(s) authorize the withdrawal and remittance of premiums from my bank/trust company/credit union account for my contribution toward the cost of the coverage I selected under the OPC Benefits program. Your treatment of each debit shall be the same as if I had personally directed you to pay the amount owing and to debit my account. Any delivery of this authorization to you constitutes delivery by me. I agree that a photocopy or electronic copy of this PAD agreement will be as valid as the original.
Signatures	I certify that all persons whose signatures are required to authorize pre-authorized debits on the account have signed below, including any required joint account holder. **Physical or electronic signature only**
Account changes	I will notify OPC Benefits if my financial institution, branch, or account number changes. To continue withdrawals without interruption, notice of any change is required at least 14 days before the next withdrawal date.

Non-sufficient funds (NSF)	If for any reason, sufficient funds cannot be withdrawn from my bank account, I agree to pay a $10 administration fee. In addition, if there is insufficient funds in my account to cover the total monthly amount due, I authorize OPC Benefits to withdraw the amount outstanding together with the current premium and NSF fee on/around the first of the following month. If the second attempt also return NSF, I understand that pre-authorized payments may be suspended, and coverage possibly terminated, after notification. If pre-authorized payments are suspended, OPC Benefits, in its sole discretion, may temporarily offer another form of payment on a non pre-authorized basis. I understand that I am responsible for any NSF charge(s) directly from my bank.
Reinstatement of coverage	If for any reason the coverage is terminated and is eligible for subsequent reinstatement, I agree to the withdrawal of any outstanding premium due prior to the reinstatement, and following notification from OPC Benefits.
Refunds	If for any reason a refund is payable to me, I authorize the transfer of funds to the account from which it was withdrawn.
Cancellation	I may cancel this authorization at any time upon written notice to the OPC.

Signed at_____ _____ on _____ _____ _____
City **Province** **Month** **Day** **Year**

Name of **account holder**

_____

Signature of **account holder**

_____

Name of **other joint account holder(s)**

_____

Signature of **other joint account holder(s),** if required for account

_____

Please return completed form via:
Fax: 1-866-445-9249 or Email: opcbenefits@principals.ca

Ontario Principals' Council | Benefits

RATE SCHEDULE

Long-term Disability – September 1, 2022

Option 1	Option 2	Option 3	Option 4	Option 5
1.54%	1.39%	1.38%	1.24%	1.77%

Your annual cost can be calculated by multiplying your salary by the rate for the option that you have selected.

Example:	**Annual Salary**		**Option Rate**		**Annual Cost**		**Monthly Cost**
If you select Option 2	$100,000	x	0.0139	=	$1,390.00 ÷ 12 months	=	$115.83

Optional Life Insurance (Member, Spouse, Dependent Children) – September 1, 2022

The monthly cost of optional member/spouse life insurance, based on 12 payments per year, is calculated on your actual age and/or your spouse's age, and whether either of you smoke. You can select coverage from **$25,000 to $200,000 as indicated below.** Please note that, as your age moves to the next age band, you will be charged the corresponding higher rate as of **September 1st.**

Age	Non-Smoker					Smoker				
	$200,000	**$150,000**	**$100,000**	**$50,000**	**$25,000**	**$200,000**	**$150,000**	**$100,000**	**$50,000**	**$25,000**
Under 30	$11.76	$8.82	$5.88	$2.94	$1.47	$18.63	$13.97	$9.31	$4.66	$2.33
30-34	$10.90	$8.17	$5.45	$2.72	$1.36	$22.62	$16.96	$11.31	$5.65	$2.83
35-39	$15.46	$11.59	$7.73	$3.86	$1.93	$31.23	$23.42	$15.61	$7.81	$3.90
40-44	$25.79	$19.34	$12.89	$6.45	$3.22	$49.25	$36.93	$24.62	$12.31	$6.16
45-49	$44.10	$33.08	$22.05	$11.03	$5.51	$79.32	$59.49	$39.66	$19.83	$9.91
50-54	$76.46	$57.35	$38.23	$19.12	$9.56	$124.85	$93.63	$62.42	$31.21	$15.61
55-59	$122.85	$92.14	$61.43	$30.71	$15.36	$188.16	$141.12	$94.08	$47.04	$23.52
60-64	$198.18	$148.63	$99.09	$49.54	$24.77	$300.13	$225.10	$150.07	$75.03	$37.52
65-69	$316.39	$237.29	$158.19	$79.10	$39.55	$471.18	$353.38	$235.59	$117.79	$58.90

The monthly cost for optional dependent life insurance based on 12 payments per year, covers all eligible children in your family. You can select coverage from **$5,000 to $20,000 in increments of $5,000:**

Coverage	Monthly Cost
$20,000	$0.77

Coverage	Monthly Cost
$15,000	$0.61

Coverage	Monthly Cost
$10,000	$0.44

Coverage	Monthly Cost
$5,000	$0.23

Optional Accidental Death and Dismemberment (AD&D)

The monthly premium for optional accidental death and dismemberment is based on 12 payments per year. You can select coverage from **$25,000 to $200,000 in increments of $25,000:**

Principal Sum	Member Coverage	Family Coverage
$ 200,000	$ 4.23	$ 6.83
$ 175,000	$ 3.70	$ 5.97
$ 150,000	$ 3.18	$ 5.12
$ 125,000	$ 2.65	$ 4.27

Principal Sum	Member Coverage	Family Coverage
$ 100,000	$ 2.12	$ 3.41
$ 75,000	$ 1.59	$ 2.56
$ 50,000	$ 1.06	$ 1.71
$ 25,000	$ 0.53	$ 0.85

The rates shown are correct at the time of printing but are subject to change.

All Rates shown above include Ontario Retail Sales Tax.

OPC BENEFITS - SUMMARY

- Long-term Disability Insurance
- Life Insurance
- Accidental Death and Dismemberment Insurance

Long-term Disability (Member only coverage)

The Long-term Disability (LTD) plan provided by the Ontario Principals' Council is underwritten by Canada Life.

What Are the Coverage Options?

You may elect one of the following five options. The benefit you receive when totally disabled is not subject to income tax when you pay 100% of the premium.

OPTION 1 – 100 days / 70%

55% of monthly salary, up to a maximum monthly benefit of $8,000. Benefits begin upon approval and after a waiting period of 100 consecutive calendar days.

Coverage / benefit terminates at the earlier of your 65th birthday or the date you are eligible for a 70 per cent unreduced pension (after 35 years of qualifying service).

OPTION 2 – 150 days / 70%

55% of monthly salary, up to a maximum monthly benefit of $8,000. Benefits begin upon approval and after a waiting period of 150 consecutive calendar days.

Coverage / Benefit terminates at the earlier of your 65th birthday or the date you are eligible for a 70 per cent unreduced pension (after 35 years of qualifying service).

OPTION 3 – 100 days / 85 factor

55% of monthly salary, up to a maximum monthly benefit of $8,000. Benefits begin upon approval and after a waiting period of 100 consecutive calendar days.

Coverage / Benefit terminates at the earlier of your 65th birthday or the date you attain the 85 factor. No minimum pension amount or age has to be attained.

OPTION 4 – 150 days / 85 factor

55% of monthly salary, up to a maximum monthly benefit of $8,000. Benefits begin upon approval and after a waiting period of 150 consecutive calendar days.

Coverage / Benefit terminates at the earlier of your 65th birthday or the date you attain the 85 factor. No minimum pension amount or age has to be attained.

OPTION 5 – 100 days / 70% / 3% COLA

55% of monthly salary, up to a maximum monthly benefit of $8,000. Benefits begin upon approval and after a waiting period of 100 consecutive calendar days, PLUS provides COLA of 3%, after 12 months of paid benefits.

Coverage / benefit terminates at the earlier of your 65th birthday or the date you are eligible for a 70 per cent unreduced pension (after 35 years of qualifying service).

Note that it is your responsibility to advise the OPC when you have attained your 85 factor or become eligible for a 70 per cent unreduced pension as you will not be entitled to LTD benefits / coverage after that date. The OPC does not have access to pension information, therefore, your coverage will not be automatically terminated on your pension eligibility date; you must notify OPC Benefits in writing.

Your LTD benefit will be reduced by all other benefits that you receive because of your disability. This includes income from the Workplace Safety and Insurance Board, the Canada Pension Plan, other group insurance disability benefits, salary continuation income, pension income, and other government benefits.

What Is a Disability?

Disability means a restriction or lack of ability due to an illness or injury which prevents you from performing the essential duties of your own occupation during the waiting period and the 24 months immediately following the waiting period. After that, you will be considered totally disabled if you are unable to perform the duties of any occupation for which you are reasonably qualified or may reasonably become qualified by training, education, or experience.

When Do Benefits Begin?

Benefits begin upon approval and after you complete the waiting period or have used your sick leave / short term leave and disability plan credits (STLDP). If you elect options 1, 3 or 5, the waiting period is 100 consecutive calendar days. If you elect options 2 or 4, the waiting period is 150 consecutive calendar days.

When Do Benefits Terminate?

Options 1, 2 or 5: Benefits terminate at the earlier of, the date you are no longer totally disabled, age 65, the date you are eligible to receive a 70 per cent unreduced pension (after 35 years of qualifying service), or retirement.

Options 3 or 4: Benefits terminate at the earlier of, the date that you are no longer totally disabled, age 65, the date you are eligible to retire with the 85 factor **regardless of the actual amount of your pension, or your age,** or retirement. These options should only be selected if you plan to retire when you reach the 85 factor.

When Is My Coverage Effective?

If you are a newly appointed Administrator in a participating District School Board and had LTD coverage up to the date of your appointment, you have 60 calendar days from the date of your appointment to join the program without medical evidence of good health. Your coverage will be effective as of the date of your appointment.

If you currently have LTD coverage under a group policy, medical evidence of good health is not required to join the OPC Benefits plan. However, satisfactory proof of coverage will be required. Coverage will be effective once satisfactory proof is received and assessed.

If you did not have LTD coverage prior to being offered coverage under the OPC Benefits plan or if you are applying after 60 calendar days, you must complete the Evidence of Insurability, as well as the Group Benefit Application forms. Your coverage will be effective as of the date your application is approved by Canada Life.

What Other Benefits Does the LTD Plan Provide?

The OPC LTD plan is more than just income replacement. It also provides the following benefits:

→ **Accelerated Survivor Benefit**
Survivor Benefit will be paid early if claimant is terminally ill.

→ **Survivor Benefit**
Three months income benefit paid to named beneficiary.

→ **Basic Critical Illness**
One-time lump sum payment of $2,500 for surviving one of the 22 covered conditions for a prescribed period of time.

→ **Teladoc Medical Experts**
Second opinion, medical supports, and mental health navigator

How Much is the Monthly Premium?

The monthly premium is based on your annual salary and the option you select. Refer to the enclosed Rate Schedule for how to calculate your monthly cost. Rates include the applicable sales tax.

Term Life Insurance (Member, Spouse, Dependent Children)

The term life insurance coverage offered by the OPC Benefits plan and underwritten by Canada Life, allows you to purchase the amount of coverage you require at a competitive cost.

Why Do You Need Optional Term Life Insurance?

The guideline for life insurance is that you should have a minimum of five times your annual salary in insurance coverage to maintain your family's lifestyle. You may already have coverage through ONE-T, and/or through mortgage and loan insurance. The life insurance plan offered by the OPC, gives you the option to increase your overall life insurance protection.

Built in Flexibility

- Insurance is available for you, your spouse, and your children
- You determine the amount of insurance to fit your needs
- You select the beneficiary of your choice. You are automatically the beneficiary for your spouse and child life insurance.

You and/or your spouse may choose $200,000, $150,000, $100,000, $50,000 or $25,000 of coverage. If you elect to be covered for optional life, you are eligible to select coverage of $20,000, $15,000, $10,000 or $5,000 for your dependent children.

For amounts up to $100,000, medical evidence of good health is not required provided you apply for coverage within 60 calendar days of your appointment to Administrator. If your District School Board participates in the OPC Benefits plan, and you are a newly appointed principal/vice-principal, you have 60 calendar days from your date of appointment to join the plan without the need to provide medical evidence of good health. Applications made after 60 calendar days of your date of appointment, and any subsequent increases in the amount of insurance coverage, will require medical evidence of good health. Please contact the OPC at 416-322-6600, 1-800-701-2362 or opcbenefits@principals.ca for more information.

Dependent children from the age of 24 hours are covered up to age 21 (up to age 25 if a full-time student). Children can be covered on a permanent basis, if they are incapacitated for a continuous period before age 21 or while a full-time student and before age 25, subject to the Member's eligibility for coverage and the Group Benefit plan termination provisions. **For this purpose**, y**ou must request and complete an application for over-age dependent form, at least within six months before age 21/25 (as applicable).**

Life insurance will be paid on death from any cause to the named beneficiary(ies). However, if death occurs due to suicide, the amount of the insurance payable, will be limited to the amount which has been in effect for one or more years. If you become totally disabled while insured for this benefit and prior to age 65, Canada Life will waive the premiums to continue the coverage for yourself and members of your family as insured.

Insurance ceases when you reach age 70 or are no longer eligible for coverage. Insurance for your spouse ceases on the earlier of, the date you are no longer an OPC Member, or the date your spouse reaches age 70. Insurance on your dependent children ceases on the earlier of the date you reach age 70, the child is no longer eligible for coverage, or you are no longer eligible for coverage.

Monthly Premium – You, Your Spouse and Your Dependent Children

The monthly cost, based on 12 payments per year, is calculated on your actual age and/or your spouse's age, and whether either of you smoke. Please refer to the enclosed Rate Schedule to determine your monthly cost for coverage for your dependent children, your spouse and yourself. Rates include the applicable sales tax.

Term Accidental Death and Dismemberment (AD&D) Coverage

Did you know that accidents are the third leading cause of death each year and are major killers of adults in their prime?

If you survive a serious accident, you could be faced with great and immediate financial hardship, because of loss of limbs, eyesight, speech or hearing. Unfortunately, no one has control over the possibility that an accident can happen. However, you do have a measure of control over your financial situation in such an event.

The OPC AD&D plan, insured by Canada Life, provides you with one more way to safeguard your family's future.

The principal sum is paid in the event of accidental death, and a percentage of the principal sum is paid in the event of dismemberment or loss of use of a limb, sight or hearing (see chart). Additional benefits are provided, such as rehabilitation allowances, training allowances and payment of day care expenses, incurred as a result of a covered accident.

You may choose between Member only coverage and family coverage. Family coverage automatically provides the following coverage for family Members:

Type of Loss	% of Principal Sum
Loss of Life	100%
Loss of or Loss of Use of Both Hands Or Both Feet	100%
Loss of or Loss of Use of Both Arms	100%
Loss of Sight of Both Eyes	100%
Loss of One Hand and One Foot	100%
Loss of One Hand and Sight of One Eye	100%
Loss of One Foot and Sight of One Eye	100%
Loss of Hearing in Both Ears and Speech	100%
Loss of or Loss of Use of One Arm Or One Leg	75%
Loss of or Loss of Use of One Hand Or One Foot	66 2/3%
Loss of Sight of One Eye	66 2/3%
Loss of Speech or Hearing in Both Ears	66 2/3%
Loss of Thumb and Index Finger or at Least Four Fingers of One Hand	33 1/3%
Loss of All Toes of One Foot	25%
Loss of Hearing in One Ear	25%
Hemiplegia, Paraplegia or Quadriplegia	200%

Spouse (no children):	The spouse is covered for 60% of the principal sum elected by the Member.
Spouse (and at least one child):	The spouse is covered for 50% of the principal sum elected by the Member and each dependent child is covered for 15% of the principal sum elected by the Member.
Children Only (no spouse):	Each child is covered for 20% of the principal sum elected by the Member.

Additional Information

If you have any questions, please call the OPC at 416-322-6600 or 1-800-701-2362, or email opcbenefits@principals.ca.

This brochure provides an overview of the coverage available and is not a valid contract. If there are any discrepancies between this brochure and the Master Policy, the provisions of the Master Policy shall govern.