SMOKER/NON-SMOKER DECLARATION FORM

Supplementary Declaration of Smoking Habits - Forming a part of an Application for Insurance		
Name of Employee:	Gender: ❒ Female	❒ Male
OPC Member #:	School Board:	
Name of Spouse (if applicable):		

Tick off the appropriate Box	Employee	Spouse (if applicable)
1. I certify that I have used tobacco products during the 12-month period immediately preceding the date written below beside my signature.	❒	❒
2. I certify that I have not used tobacco products during the 12-month period immediately preceding the date written below beside my signature	❒	❒

I understand and agree that the premiums charged for my (or my spouse's) insurance coverage are based in part on the statements given by me (or my spouse) on this form. I certify that the statements are accurate, true and complete in all respects. If any such statement is inaccurate, untrue or incomplete in any respect, I understand and agree that all insurance coverage is voidable by the insurer. I further agree that in such event, the insurer's liability to paying to the designated beneficiary/beneficiaries, is the amount of any premium I paid for insurance coverage.

Employee Signature: _____ Date _____

Spouse Signature: _____ Date _____
(if applicable)

Please return the completed form to:

OPC Benefits

Email: opcbenefits@principals.ca
Fax: 1-866-445-9249
Post: 20 Queen St. W., Suite 2700
PO Box 7
Toronto, Ontario
M5H 3R3