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 elimination period, terminates when you are eligible for a 70% unreduced pension.

❒ Option 2 – 150 calendar day elimination period, terminates when you are eligible for a 70% unreduced pension.

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

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

❒ Option 5 – 100 calendar day elimination period, terminates when you are eligible for a 70% unreduced pension.

PLUS, COLA of CPI to a maximum 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% unreduced pension as you will not be entitled to LTD benefits/coverage after that date. Your coverage will not 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) or I did not have prior LTD coverage* ❒ Yes ❒ No
- I currently have LTD coverage under a Group or Individual Policy and wish to switch to the OPC Plan** ❒ Yes ❒ No

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

***If you are applying for coverage as a late applicant i.e. after 60 days of your initial appointment to administrator, if your application was received after 60 days, of if you did not have continuous LTD coverage up to the date of appointment, you must complete the evidence of insurability (EOI) form. The effective date of coverage will be the date the application is approved by Canada Life.**

Authorization I hereby authorize any physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance company or other organization, institution or person that has any records or knowledge of me or my health, to give to Canada Life any and all information about me with reference to my health and medical history and any hospitalization, advice, diagnosis, treatment, disease, ailment or condition. Information may be used for audit purposes by a third party. All information obtained will be treated as confidential. In support of the claims process the OPC may receive copies of the above information. A photocopy of this authorization shall be as valid as the original. I may receive a copy upon request.

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 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, DATE AND MAIL WITH YOUR CHEQUE MARKED "VOID"

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. In order to ensure the confidentiality of the personal information held concerning you, 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, 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 or bank. If premiums are to be collected by bank deduction, I authorize the monthly deduction and remittance of premiums from my bank / trust company / credit union account for my contribution toward the cost of these benefits. The initial deduction may cover up to three monthly premiums. If more than one signature is required on your joint account, all depositors 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.

Further, you authorize your employer____ to release information regarding your employment status including attendance records, salary information and job description to the OPC in order to allow for the administration of the Program and accurately calculate premiums under the Program.

Applicant Signature: ____ Date: ____________________

Signature of Joint Account Depositor: ____ Date: ____________________
(if required for Joint Account)

If you have any questions, please call OPC Benefits at 416-322-6600 or 1-800-701-2362, write to OPC Benefits at 2700 - 20 Queen St.W., P.O Box 7. Toronto, ON, M5H 3R3 or email at opcbenefits@principals.ca