OTIP Benefits Services
PO Box 218
Waterloo ON N2J 3Z9
1-866-783-6847
www.otip.com

Long Term Disability Insurance Application Form

IMPORTANT: (Please print all answers.)

1. Please ensure that **ALL SECTIONS** are completed.
2. Please submit your Long Term Disability Insurance Application to your employer.
3. **If required, retain a copy for your files.**

MEMBER BASIC PERSONAL INFORMATION

Plan Member Name (First, Middle Initial and Last)			Sex ☐ Male ☐ Female
Address (Number, Street and Apt.)			Date of Birth *(mm/dd/yyyy)*
City/Town	Province	Postal Code	Date of Hire *(mm/dd/yyyy)*
Home Telephone Number	Work Telephone Number		Date Eligible for Benefit *(mm/dd/yyyy)*
Email Address			Effective Date *(mm/dd/yyyy)*
Employee Number	Plan Number	School Board	

Indicate Membership of: ☐ PRINCIPAL / VICE-PRINCIPAL ☐ SUPPORT STAFF ☐ EDUCATIONAL ASSISTANTS ☐ CLERICAL
☐ ADMINISTRATION ☐ RETIREE ☐ TRADESPERSON ☐ OTHER ________________

Yearly Gross Salary (including allowances, excluding overtime)

$ ______ .00

LONG TERM DISABILITY

☐ YES, I WISH TO HAVE LONG TERM DISABILITY COVERAGE.

I authorize the Board to make payroll deductions as applicable and authorize the use of my employee number for the administration of my benefits applied for under this application.

☐ NO, I WAIVE MY RIGHT TO LONG TERM DISABILITY COVERAGE.

I understand that if I choose to apply for coverage at a later date, evidence of insurability will be required.

AGREEMENT, ACKNOWLEDGEMENT AND AUTHORIZATION

I hereby make application for benefits as outlined above and certify that the information disclosed herein is accurate and complete. I consent to such information being used for the purpose of understanding my needs, evaluating my eligibility for the plan, providing me with ongoing services, protecting us both against error and fraud and complying with various legal requirements.

I authorize the Board to make payroll deductions as applicable and authorize the use of my employee number for the administration of my benefits applied for under this application. I further authorize the plan administrator, OTIP, to act on my behalf in dealing with the insurance carrier of the existing policy or any successor policy, concerning my application for group insurance, changes in insurance, notification of insured information and any other administrative matters.

I understand that this authorization terminates on the earlier of the change in my employment status with the Group/Board which affects my eligibility under the policy, or a termination of the insurance between the Group/Board and the plan administrator, OTIP.

Signature of Plan Member ____________________ **Date** *(mm/dd/yyyy)* ____________

Please mail the completed form to:

OTIP Benefits Services
PO Box 218
Waterloo ON N2J 3Z9