OTIP RAEO®

OTIP Benefits Services
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Overage Dependent Student Form

Reset

IMPORTANT: (Please print all answers)

1. All sections to be completed by the plan member unless otherwise indicated.
2. Please complete, sign and send this form to the above mailing address.
3. Please retain copies for your files.

SECTION 1: MEMBER BASIC PERSONAL INFORMATION

Plan Member Name (First, Middle Initial and Last)			Gender ☐ Male ☐ Female
Address (Number, Street and Apt.)		City/Town	Province / Postal Code
Home Telephone Number	Work Telephone Number	Date of Birth *(mm/dd/yyyy)*	
OTIP Identification Number	Plan Number	Email Address	

SECTION 2: DEPENDANT STUDENT INFORMATION

You are required to **complete this form each school year for every dependent student**, who is over the maximum age listed in your benefits contract as outlined in your benefits booklet and who meets all of the criteria defining an overage dependent student. Your benefits contract defines an overage dependent student as a person who is:

- Your or your spouse's natural, legally adopted, step or foster child.
- In full-time attendance at an accredited educational institution.
- Unmarried.
- Not engaged in full-time employment.
- Dependent on you or your spouse for financial support.

Please provide the following information for each dependant to be insured.

Complete Name of Eligible Dependant *(First, Middle Initial and Last)*	**Gender**	**Date of Birth** *(mm/dd/yyyy)*	**School Year Start** *(mm/yyyy)*	**School Year End** *(mm/yyyy)*	**Name of School**
	☐ Male ☐ Female				
	☐ Male ☐ Female				
	☐ Male ☐ Female				
	☐ Male ☐ Female				

SECTION 3: CERTIFICATION AND AUTHORIZATION

I certify that I (being the plan member, spouse or dependant with the capacity to contract, whichever is applicable) am applying for this benefits coverage/ insurance ("Coverage") and that the information provided for this application is true and complete. I understand that the Coverage is insured through a group benefits insurance carrier ("Insurer"). I agree that my Coverage may be denied or terminated at any time by the Insurer as a result of any false, incomplete, or misleading information having been provided in this application. I authorize the Insurer to collect, use, maintain and disclose my personal information relevant to this application ("Information") for the purposes of benefits plan administration, audit and the assessment, investigation, or management of this application, and medical underwriting (collectively, the "Purposes"). I also authorize OTIP to collect, use, maintain and disclose Information for the purpose of benefits plan administration. I am authorized to consent to the collection, use, maintenance, exchange and disclosure of Information pertaining to any minor child who may be the subject of this application for Coverage, for the Purposes, and all of the statements made herein on my own behalf shall apply equally to such minor child.

I understand that the Insurer may investigate this application and may require Information about me for the Purposes, including information regarding activities, income, employment, education and training, health and medical history and treatment, including clinical notes. I authorize any person or organization with Information, including any medical or health professionals, facilities or providers, professional regulatory bodies, any employer, plan administrator, plan sponsor, insurer, investigative agency, and any administrators of other benefits programs to collect, use, maintain and exchange this Information with each other, including OTIP, the Insurer, its reinsurers and/or service providers, for the Purposes. I understand that any Coverage shall not become effective until approved by OTIP and by the Insurer. I authorize the use of my OTIP identification number for the purposes of identification and administration. I agree a photocopy or electronic version of this authorization is valid. I acknowledge that more specific details regarding how and why OTIP and the Insurer collect, use, maintain, and disclose my personal information can be found in OTIP's Privacy Policy available at www.otip.com, or the Insurer's Privacy Policy available at www.manulife.com, or by request.

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

Any Information provided to or collected by OTIP in accordance with this authorization, will be kept in a benefits health file. Access to your Information will be limited to:

- OTIP employees, OTIP's representatives, OTIP's insurer and their reinsurers and service providers in the performance of their jobs;
- Persons to whom you have granted access; and
- Persons authorized by law.

You have the right to request access to the personal information in your file, and, where appropriate, to have any inaccurate information corrected.