OTIP RAEO

ONTARIO TEACHERS INSURANCE PLAN
P. O. Box 218
125 Northfield Drive West
Waterloo ON N2J 3Z9
(519) 888-9683
1-800-267-6847

LONG TERM DISABILITY - MANDATORY ENROLLMENT TERMINATION OF COVERAGE APPLICATION

BASIC PERSONAL DATA (MUST BE COMPLETED)

NAME _____ (LAST) _____ (FIRST) _____ (MIDDLE) GENDER F ☐ M ☐

ADDRESS _____

CITY _____

POSTAL CODE _____ PHONE _____ – _____

EMPLOYEE TYPE (CHECK ONE)

INDICATE MEMBERSHIP OF:

OECTA	ELEM ☐	ADMINISTRATION	☐
	SEC ☐	CLERICAL	☐
ETFO	☐	TRADESPERSON	☐
OSSTF TEACHER	☐	OTHER _____	

E-MAIL ADDRESS _____

SOC. INS. NO. _____ EMPLOYEE NO. _____ DATE OF BIRTH _____ (MONTH) _____ (DAY) _____ (YEAR)

BOARD _____ DATE OF HIRE WITH BOARD _____ (MONTH) _____ (DAY) _____ (YEAR)

POLICY NO. _____ EFFECTIVE DATE _____ (MONTH) _____ (DAY) _____ (YEAR)

SPECIAL NOTE

A request for cancellation can only be approved by your federation and OTIP. Coverage cannot be cancelled retroactively. Cancelling your long term disability insurance (LTD) coverage should only be done after serious consideration of potential consequences.

A written request to retire, which includes your intended retirement date, MUST accompany this form prior to approval of this termination request being granted.

A copy of my retirement notice is attached. ☐

I, _____, wish to terminate my LTD coverage effective ____/____/____
(print full name) mm/dd/yyyy

and hereby authorize the board to cease payroll deductions as applicable for the above LTD plan.

Note: If a request for cancellation is received by the 15th of a month, coverage will be cancelled on the 1st of the following month. If the request is received after the 15th of the month, coverage will be cancelled on the 1st of the 2nd month following receipt.

In recognition of the documentation attached, I waive all rights of benefit or redress against the LTD plan, or my federation, or its officers, should I become ill or disabled subsequent to the effective date of this termination request and prior to my retirement from the board. I further understand that if I wish to re-apply for LTD coverage in the future, I will be required to submit satisfactory proof of insurability at my own expense and subject to the insurance carrier's approval.

Date ____/____/____ Signature _____
mm/dd/yyyy