OTIP Group Life and Disability Claims
PO Box 218
Waterloo ON N2J 3Z9
1.800.267.6847 | www.otip.com

Application for Special Advance Payment

ELIGIBILITY: The member must be terminally ill with a life expectancy of 12 months or less and must be approved for waiver of premium. Eligibility for this loan is subject to Group Benefits Policy's terms and conditions.

PLEASE COMPLETE THE FOLLOWING INFORMATION.

1. Plan Member and Policy Information

Name: First ______________________ Initial ________ Last ______________________

Home Address: ____

City: ______________________ Province: ________ Postal Code: ______________

Telephone Number: ______________________ Mobile Number: ______________________

Date of Birth: *(mm/dd/yyyy)* ______________________

Group Policy Number: *(e.g. 105123)* ______________________ Location (Class): *(e.g. 123)* __________

OTIP ID Number: ______________________

2. Medical Information

Attending Physician's Full Name: ____

Address: ______________________________ Telephone Number: ______________

City: ______________________ Province: ________ Postal Code: ______________

Current diagnosis: ____

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3. Loan Information

Amount of Basic Life Insurance: ______________________ Amount of Loan Requested: ______________

Amount of Optional Life Insurance (if applicable): ______________ Amount of Loan Requested: ______________

(Maximum loan is the lesser of 50% of the plan member's combined basic and optional life insurance or a maximum of $50,000).

APPLICATION FOR SPECIAL ADVANCE PAYMENT (CONTINUED)

Certification and Authorization:

I certify that the information in this form, and any further verbal or written statement provided by me in the future, is true and complete to the best of my knowledge.

I agree that both my claim and my coverage may be denied or terminated as a result of my providing false, incomplete, or misleading information.

I agree to repay, and direct my estate to repay, any monies that I may owe, including any applicable interest as outlined in the Group Benefits Policy to OTIP and its insurer, in accordance with the provisions of the benefits plan.

I authorize OTIP as the administrator for my ELHT benefits plan and its insurer to deduct such monies from my life insurance benefits.

I understand that OTIP and its insurer will investigate this claim.

I authorize any person or organization who has Information pertaining to this claim, including any employer, plan administrator, plan sponsor, health-care professional, health-care institution, pharmacy and any other medically-related facility, rehabilitation provider, insurer, administrators of government benefits or other benefit programs, the Medical Information Bureau and investigative agency (“Information”), to release and exchange Information requested by OTIP and its insurer for the purpose of administering the group plan and assessing my claim.

I authorize OTIP, its Insurer and their reinsurers and/or service providers to collect, use, maintain, and exchange to the persons or organizations listed above and/or each other any Information needed for the purposes of plan administration, claim assessment, audit, investigation and management of my claim (“Purposes”).

I authorize the above collection use and exchanges of my personal information yearly and as required by the above-named parties.

I authorize the use and disclosure of my Social Insurance Number for tax reporting.

I agree that a photocopy or electronic version of this authorization shall be as valid as the original.

I understand that OTIP’s Privacy Policy is available at www.otip.com or by request.

Claimant’s Name *(please print)*: ____________________

Claimant’s Signature: ____________________ **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 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 Information in your file, and, where appropriate, to have any inaccurate information corrected.