OPP ASSOCIATION GROUP INSURANCE FORM – STUDENT UPDATE

Surviving Eligible Dependents – Dependents 22 years of age & over

OPPA Policy: #335453

1. Surviving Member Information:

Last Name	**First Name** **Initial**
Personal Email Address:	**Contact Number:** □ Cell □ Home □ Work
OPPA ID #	

School Year: September 1, 20____ to August 31, 20____ ***Student updates are valid for one year and must be updated annually.***

2. DEPENDENT INFORMATION

Add/Change/ Remove	Last Name	First Name	Date of Birth (dd/mm/yy)	Gender	If dependent child is 21 years of age or older	
					Full-time Student	Disabled
□ Add □ Change □ Remove				□ Male □ Female	□ Yes □ No	□ Yes □ No
□ Add □ Change □ Remove				□ Male □ Female	□ Yes □ No	□ Yes □ No
□ Add □ Change □ Remove				□ Male □ Female	□ Yes □ No	□ Yes □ No

3. STUDENT HEALTH BENEFITS: if you have indicated " Yes" above, please complete the following;

Insurance Company : _____		**Policy #** _____		
Please indicate what benefits are covered:	□ Drugs	□ Dental	□ Vision	□ Hospital

PRIVACY: The Ontario Provincial Police Association, Target Benefits Administrators and the Insurers recognize and respect the importance of privacy. The personal information collected on this form is necessary to process your application. The information is required in order to ensure your eligibility for the benefit, that the payment of claims is correct, to respond to your questions and for audit purposes. Access to your file is limited to staff or persons authorized by us who require it to perform their duties, to persons to whom you have granted access and to persons authorized by law. The insurers may use service providers located within or outside Canada. Your personal information may be subject to disclosure to those authorized under applicable law within or outside Canada.

AUTHORIZATION & DECLARATIONS - I authorize:

The Ontario Provincial Police Association and their administrator to deduct the required premiums from my pay/pension, if applicable; The use of my OPPA ID number as a unique identification number where it is required to protect employee privacy and confidentiality in the administration of the plan;
Any health care provider, my plan administrator, administrators of government benefits or applicable service providers, to exchange personal information when necessary to determine my eligibility for coverage and to administer the plan; The insurers to use my social insurance number for tax reporting purposes and as an identification number where it is required in the administration of the plan; If applying for coverage for my dependent children, I certify my insurable interests and confirm that I am authorized to act on their behalf;

I certify that the information given is true, correct and complete to the best of my knowledge.

_____	_____	_____
Signature of Member	**Print Name**	**Date Signed (dd/mm/yy)**

Effective date of Coverage (dd/mm/yy)	_____ Signature of Authorized Official	_____ Date Signed (dd/mm/yy)

If making changes please send completed form to:	**For Inquiries:**
Target Benefit Administrators **204 – 5100 Orbitor Dr., Mississauga ON L4W 4Z4** **Email: targetforms@wlvinc.com** **Fax: 416-740-2291**	**Tel. 1-888-660-6055** **Email: target@wlvinc.com**