

OPP ASSOCIATION GROUP INSURANCE FORM

OPP Insured Benefits Policy #s: 044501/006772

OPP/OPPA Insurance Policy #s: 158009, 335354/55/56, 167997, 056/022557A/022558A, 100009152, 056CI/024565A, 44501/6772

Section 1. MEMBER INFORMATION:

New Application

Change

UNIFORM CIVILIAN OPP WIN: _____
 RETIREE OPB Client ID: _____

Last Name	Legal First Name	Preferred Name
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Home Address:

City: _____ Prov/Terr: _____ Postal Code: _____

Date of Birth (mm/dd/yyyy): _____ Gender: Male Female Undisclosed

Main Telephone Number: Cell Home Work _____

Alternate Telephone Number: Cell Home Work _____

Personal E-mail Address: _____

Section 2. REASON FOR CHANGE/LIFE EVENT

Life events include - marriage, cohabitation, divorce/marital breakdown, birth, adoption, or death of a dependent.

Please check the appropriate box for the reason(s) and indicate effective date:

<input type="checkbox"/> Marriage	<input type="checkbox"/> Separation - Marriage	<input type="checkbox"/> Birth	<input type="checkbox"/> Legal Change/Other (please specify)
<input type="checkbox"/> Cohabitation	<input type="checkbox"/> Divorce	<input type="checkbox"/> Adoption	
	<input type="checkbox"/> Separation - Cohabitation		

Date (mm/dd/yyyy)	Date (mm/dd/yyyy)	Date (mm/dd/yyyy)
_____	_____	_____

Section 3. INSURED BENEFIT INFORMATION

Member	Health/Vision/Drugs:	<input type="checkbox"/> Single	<input type="checkbox"/> Family	<input type="checkbox"/> None
	Dental Plan:	<input type="checkbox"/> Single	<input type="checkbox"/> Family	<input type="checkbox"/> None

Coordination of Benefits (COB): Do you or any insured member of your family have coverage through other benefit plans?

<input type="checkbox"/> Yes	<input type="checkbox"/> Spouse <input type="checkbox"/> Other* If Spouse, are they an OPPA member: <input type="checkbox"/> Yes <input type="checkbox"/> No
	Name of insured: _____ Date of Birth (mm/dd/yyyy): _____
	Effective Date of coverage: _____
	Coverage includes: <input type="checkbox"/> Drugs <input type="checkbox"/> Health <input type="checkbox"/> Vision <input type="checkbox"/> Dental Status: <input type="checkbox"/> Single <input type="checkbox"/> Family

<input type="checkbox"/> No	If removing a spouse COB - Was the spouse an OPPA Member: <input type="checkbox"/> Yes <input type="checkbox"/> No
	Name: _____ Effective Date (mm/dd/yyyy): _____

* Special Co-ordination of Benefits ONLY:

If eligible dependent children have additional coverage other than the OPPA member and eligible spouse on file, provide details of coverage including order of payment.

Parent's Name: _____ Date of Birth (mm/dd/yyyy): _____

Is coverage currently in place: Yes No Coverage Included: Drugs Health Vision Dental

Name(s) of Dependents eligible: _____

Section 4. DEPENDENT INFORMATION

Relationship To Employee	Add/ Change/ Remove	Last Name	First Name	Date of Birth (mm/dd/yy)	Gender	If dependent child is 21 years of age or older	
<input type="checkbox"/> Married <input type="checkbox"/> Common law	<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Remove				<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Undisclosed	<input type="checkbox"/> Full-time Student	<input type="checkbox"/> Disabled
Dependent Child	<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Remove				<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Undisclosed	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent Child	<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Remove				<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Undisclosed	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent Child	<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Remove				<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Undisclosed	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent Child	<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Remove				<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Undisclosed	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent Child	<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Remove				<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Undisclosed	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Sections 5 – 8: Complete if changes are being made to current coverage.

To reduce or cancel insurance(s), please contact Target Benefits at 1-888-660-6055 or target@wlvinc.com

Active members on a leave of absence due to illness/disability (WSIB / LTIP) and Retired members cannot add or increase insurances.

Section 5. OPP MEMBER & DEPENDENT LIFE INSURANCE

OPP Basic Life	<input checked="" type="checkbox"/> Yes Active – 1x salary (no cost)	Retired - \$2,000 (no cost)	<input type="checkbox"/> Waived (Irrevocable if waived)	
OPP Supplementary Life - Optional *	Active- \$0.28/\$1,000/month Retired- \$0.28/\$1,000/month	<input type="checkbox"/> 1x Salary	<input type="checkbox"/> 2x Salary	<input type="checkbox"/> 3x Salary
OPP Dependent Life – Optional \$2,000 (spouse) / \$1,000 (child)	<input type="checkbox"/> One dependent \$0.15/month	<input type="checkbox"/> More than one dependent \$0.30/month		<input type="checkbox"/> None

* Subject to approval through Evidence of Insurability, if applied for after 31 days of Hire/Life Event.

Section 6. OPPA MEMBER & DEPENDENT LIFE INSURANCE

OPPA Basic Life & AD&D \$10,000 each	Active - no cost Retired - no cost	<input checked="" type="checkbox"/> Yes																																				
OPPA Basic Life & AD&D Increase – Optional * \$10,000 each	Active - \$3.30/month Retired - \$3.30/month	<input type="checkbox"/> Yes	<input type="checkbox"/> No																																			
OPPA Life \$20,000	Active - \$7.23/bi-weekly Retired - \$15.72/month	<input checked="" type="checkbox"/> Yes	Mandatory for active members Optional for retirees																																			
OPPA Basic Retiree AD&D \$25,000	Active - N/A Retired - no cost	<input checked="" type="checkbox"/> Yes																																				
OPPA Dependent Life – Optional ** \$6,000 per dependent	Active – no cost Retired - \$1.40/month	<input type="checkbox"/> Yes	<input type="checkbox"/> No																																			
OPPA Spousal Life - Optional Must submit Form 400 – Spousal Evidence of Insurability available at www.oppa.ca	<input type="checkbox"/> OPTION A: \$30,000 <table border="1"><thead><tr><th>Age</th><th>Under 40</th><th>\$1.67/mth</th></tr></thead><tbody><tr><td>40 – 44</td><td>\$3.33/mth</td></tr><tr><td>45 – 49</td><td>\$5.48/mth</td></tr><tr><td>50 – 54</td><td>\$8.34/mth</td></tr><tr><td>55 – 59</td><td>\$14.31/mth</td></tr><tr><td>60 – 64</td><td>\$20.98/mth</td></tr><tr><td>65 – 69</td><td>\$15.85/mth</td></tr><tr><td>(65+ eligible for \$15,000)</td><td></td></tr></tbody></table>	Age	Under 40	\$1.67/mth	40 – 44	\$3.33/mth	45 – 49	\$5.48/mth	50 – 54	\$8.34/mth	55 – 59	\$14.31/mth	60 – 64	\$20.98/mth	65 – 69	\$15.85/mth	(65+ eligible for \$15,000)		<input type="checkbox"/> OPTION B: \$60,000 <table border="1"><thead><tr><th>Age</th><th>Under 40</th><th>\$3.34/mth</th></tr></thead><tbody><tr><td>40 – 44</td><td>\$6.67/mth</td></tr><tr><td>45 – 49</td><td>\$10.97/mth</td></tr><tr><td>50 – 54</td><td>\$16.69/mth</td></tr><tr><td>55 – 59</td><td>\$28.62/mth</td></tr><tr><td>60 – 64</td><td>\$41.96/mth</td></tr><tr><td>65 – 69</td><td>\$31.70/mth</td></tr><tr><td>(65+ eligible for \$30,000)</td><td></td></tr></tbody></table>			Age	Under 40	\$3.34/mth	40 – 44	\$6.67/mth	45 – 49	\$10.97/mth	50 – 54	\$16.69/mth	55 – 59	\$28.62/mth	60 – 64	\$41.96/mth	65 – 69	\$31.70/mth	(65+ eligible for \$30,000)	
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* Subject to approval through Evidence of Insurability, if applied for after 31 days of Hire/Life Event.

** OPPA Dependent Life – Spouses are subject to approval through Evidence of Insurability if applied for >31 days of Hire/Life Event.

Note: Stepchildren are eligible when their insured parent is eligible.

Section 7. OPPA OPTIONAL ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) PLAN

Coverage available in plans for Member Only or Member & Family from \$50,000 to \$500,000 in \$25,000 units.

<input type="checkbox"/> New Insurance <input type="checkbox"/> Change in Coverage	<input type="checkbox"/> Member Only Coverage <input type="checkbox"/> Member & Family Coverage	Amount of Coverage: \$50,000 to \$500,000 in \$25,000 increments \$ _____
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If there is eligibility through more than one OPPA member, the combined maximum coverage for Accidental Death is \$500,000/member and \$75,000/child.

Rates* are based on the amount of coverage and type of plan. Below are examples of coverage and cost

Member only plan	\$50,000: \$3.02	\$100,000: \$6.05	\$250,000: \$15.12	\$500,000: \$30.24
Member/Family plan	\$50,000: \$4.00	\$100,000: \$7.99	\$250,000: \$19.98	\$500,000: \$39.96

Section 8. OPPA OPTIONAL CRITICAL ILLNESS INSURANCE PLAN

**Coverage for 31 medical conditions for Member & Spouse (\$5,000 to \$250,000) and
16 medical conditions for children (\$5,000 to \$25,000)**

New Insurance Increase in Insurance

<input type="checkbox"/> MEMBER <input type="checkbox"/> Smoker <input type="checkbox"/> Non-Smoker	Amount of Coverage: \$5,000 to \$250,000 in \$5,000 increments \$ _____	\$5,000 - \$50,000 added directly as Guaranteed Issue. Over \$50,000 medical approval required Form 500 Critical Illness Medical Application is available from the Member benefit services section of the OPPA website or through Target Benefit Administrators.
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Coverage is only available to spouse and children in amounts less than or equal to the amount of coverage on member.

<input type="checkbox"/> SPOUSE <input type="checkbox"/> Smoker <input type="checkbox"/> Non-Smoker <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Undisclosed Name: _____ Date of Birth (mm/dd/yyyy): _____	Amount of Coverage: \$5,000 to \$250,000 in \$5,000 increments \$ _____	\$5,000 - \$25,000 added directly as Guaranteed Issue. Over \$25,000 medical approval required Form 500 Critical Illness Medical Application is available from the Member benefit services section of the OPPA website or through Target Benefit Administrators.
<input type="checkbox"/> CHILD(REN)	Amount of Coverage: <input type="checkbox"/> \$ 5,000 (\$3.14) per month <input type="checkbox"/> \$ 10,000 (\$6.28) <input type="checkbox"/> \$ 15,000 (\$9.42) <input type="checkbox"/> \$ 20,000 (\$12.56) <input type="checkbox"/> \$ 25,000 (\$15.70)	The coverage and premium for children apply to all eligible dependent children on file. Maximum coverage is \$25,000/child even if there is eligibility through more than one OPPA member.

Member's signature _____ Date _____ This section applies to Critical Illness only.

Rates* are based on age, gender and smoking status. Below are a few examples of coverage and monthly cost:

Female, age 30, non-smoker:	\$50,000	\$9.70
Male, age 30, smoker:	\$50,000	\$10.90
Undisclosed, age 30, smoker:	\$50,000	\$12.60

Female, age 35, smoker:	\$50,000	\$18.30
Male age 35, non-smoker:	\$50,000	\$10.00
Undisclosed age 35, non-smoker:	\$50,000	\$11.50

Applicable Provincial Sales Tax is included in all premium examples shown.

* Please refer to the Critical Illness Plan and AD&D Plan Overviews and Booklets which can be found in the Member benefit services area of the OPPA website www.oppa.ca for coverage, terms, conditions, exclusions and premium details.

Section 9. APPOINTMENT OR CHANGE OF BENEFICIARY(IES) (use reverse of form or separate page if more space is needed)

Beneficiary designations will be the same on ALL OPP/OPPA Policies unless you indicate NO.

If NO, please complete Multiple Beneficiary Designation form.

NO

I hereby revoke all previous beneficiary designations and designate the following as beneficiary(ies).

PRIMARY BENEFICIARY(IES): if designating percentages amongst beneficiaries, they must total 100% to be valid

Last Name	First Name	Initial	Date of Birth mm/dd/yyyy if under 18 yrs.	Relationship to Employee	% (must total 100%) or Amount
1.					
Contact Information: Email:			Phone/Cell:		
2.					
Contact Information: Email:			Phone/Cell:		
3.					
Contact Information: Email:			Phone/Cell:		
4.					
Contact Information: Email:			Phone/Cell:		
<p>*Where Quebec law applies and you have designated your married spouse or civil union spouse as beneficiary, the designation will be irrevocable unless you check the box marked "revocable"; I hereby make the above beneficiary designation:</p> <p><input type="checkbox"/> Revocable, I may change this beneficiary at any time.</p>					

CONTINGENT BENEFICIARY(IES): if designating percentages, they must equal 100% to be valid

If there are no surviving primary beneficiary(ies) at the time of my death, I declare that the following Contingent Beneficiary(ies) shall receive the proceeds. If there are no surviving Contingent Beneficiary(ies) at the time of my death, the proceeds shall be paid to my Estate.

Last Name	First Name	Initial	Date of Birth mm/dd/yyyy if under 18 yrs.	Relationship to Employee	% (must total 100%) or Amount
1.					
Contact Information: Email:			Phone/Cell:		
2.					
Contact Information: Email:			Phone/Cell:		
3.					
Contact Information: Email:			Phone/Cell:		
4.					
Contact Information: Email:			Phone/Cell:		

FOR QUEBEC RESIDENTS ONLY:

Benefits payable under this plan to a beneficiary who, at the time of payment is to be made, is a minor or lacks legal capacity, will be paid to his/her tutor(s) or curator(s), unless a valid trust has been established for the benefit of the beneficiary, by Will or by separate contract, to receive any such payment and the insurance carrier has been provided notice of the trust. If a valid trust has already been established, designate the trust as the beneficiary in this section. Before designating a trust, you should seek legal advice.

TRUSTEE APPOINTMENT – required if a named beneficiary is under 18 years of age (Not Applicable to Quebec Residents)

If designating a beneficiary who is a minor or who lacks legal capacity, you may wish to appoint a trustee/administrator by completing this section. This appointment may not be suitable for all purposes. If you are designating a trustee/administrator, we recommend you consult with a legal advisor and with any proposed trustee/administrator.

I hereby appoint the following trustee/administrator to receive and hold in trust, on behalf of any beneficiary, money payable to the beneficiary under this group insurance plan where, at the time payment is made, the beneficiary is a minor or otherwise lacks legal capacity. Any such payment, to its extent, will release the Insurer or the Administrators of the Plan from further liability.

Last Name	First Name	Initial	Relationship to Employee
Contact Information: Email:			Phone/Cell:

Section 10. PRIVACY

The Ontario Provincial Police Association, Target Benefit 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.

Section 11. AUTHORIZATION & DECLARATIONS

I authorize:

The Ontario Government & the Ontario Pension Board administrator to deduct the required premiums from my pay/pension; The use of my WIN ID or Client 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 spouse and/or 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 (mm/dd/yyyy)

Inked signature or Adobe/Docusign Signature with embedded audit is required for Beneficiary Designations to be valid. Forms may be submitted via email, mail, or by facsimile.

Please return completed form to the appropriate address/email below:

Existing Active Members / Retired Members	New Hires/Transfers from Fixed-Term to Regular status within the OPP / Transfers from Fixed-Term or Regular status within the Ontario Public Service
Target Benefit Administrators 5100 Orbitor Dr., Suite 204 Mississauga ON L4W 4Z4 Email: targetforms@wlvinc.com or fax: 416-740-2291 Inquiries: 416-740-1335 / 1-888-660-6055 / target@wlvinc.com	Ontario Provincial Police Association 119 Ferris Lane Barrie ON L4M 2Y1 Email: benefits@oppa.ca Inquiries: 705-728-6161 / 1-800-461-4282 / oppa@oppa.ca

OFFICE USE ONLY:

Date of Hire (mm/dd/yy)	OPP Association Effective Date of Coverage	OPP Effective Date of Coverage	Continuous Employment Date

Transfers of non-OPPA OPP/OPS Employee Groups to OPPA Membership

Non-OPPA Employee (OPP/OPS)	Regular Full time or RPT transfers from OPP/OPS only Supplementary and/or Dependent Life insurance in place on transfer date as confirmed by Ontario Shared Services			
<input type="checkbox"/> Regular Full time <input type="checkbox"/> Regular Part time (RPT) <input type="checkbox"/> Fixed-term (FXT)	<input type="checkbox"/> SLI 1X	<input type="checkbox"/> SLI 2X	<input type="checkbox"/> SLI 3X	<input type="checkbox"/> NA
	<input type="checkbox"/> DLI – One	<input type="checkbox"/> DLI – More than One	<input type="checkbox"/> NA	

Signature of Authorized Official	Date Signed (mm/dd/yyyy)
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