OPP ASSOCIATION GROUP INSURANCE FORM
For Surviving Eligible Dependents with Insured Benefits & Life Insurance

OPP Insured Benefits Policy #006772
OPPA Insurance Policy #s: 335354/55, 056/022558A

Section 1. SURVIVOR INFORMATION: ☐ New Application ☐ Change

OPPA ID#:	**Date of Birth (mm/dd/yyyy):**	
Last Name	**Legal First Name**	**Preferred Name**
Home Address: **City:**	**Prov/Terr:**	**Postal Code:**
Main Telephone Number: ☐ Cell ☐ Home ☐ Work		
E-mail Address:	**Gender:** ☐ Male ☐ Female ☐ Undisclosed	

Section 3. GROUP INSURANCE INFORMATION

Member	**Health/Vision/Drugs:**	☐ Single	☐ Family	☐ None
	Dental Plan:	☐ Single	☐ Family	☐ None

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

☐ **Yes**
☐ **No**

If YES, please indicate the following:

Name of insured: ______________________ Date of Birth (mm/dd/yyyy): ______________

Effective Date of coverage: ______________

Coverage includes: ☐ Drugs ☐ Health ☐ Vision ☐ Dental **Status:** ☐ Single ☐ Family

**** 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 3. 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	
☐ Married ☐ Common law	☐ Add ☐ Change ☐ Remove				☐ Male ☐ Female ☐ Undisclosed	**Full-time Student**	**Disabled**
Dependent Child	☐ Add ☐ Change ☐ Remove				☐ Male ☐ Female ☐ Undisclosed	☐ Yes ☐ No	☐ Yes ☐ No
Dependent Child	☐ Add ☐ Change ☐ Remove				☐ Male ☐ Female ☐ Undisclosed	☐ Yes ☐ No	☐ Yes ☐ No
Dependent Child	☐ Add ☐ Change ☐ Remove				☐ Male ☐ Female ☐ Undisclosed	☐ Yes ☐ No	☐ Yes ☐ No
Dependent Child	☐ Add ☐ Change ☐ Remove				☐ Male ☐ Female ☐ Undisclosed	☐ Yes ☐ No	☐ Yes ☐ No

Section 4. OPTIONAL INSURANCE COVERAGE

If applicable, you are eligible to continue optional insurance coverage; applicable premiums will be deducted from your pension payment.

Insurance Eligibility OFFICE USE ONLY	Dependent Life (Policy # 335354) ☐ No Coverage ☐ $6,000	Spousal Life (Policy #335355) ☐ No Coverage ☐ Yes: $ _____	Accidental Death & Dismemberment (Policy #056/22558A) ☐ No Coverage ☐ Yes: $ _____
Insurance Election	Dependent Life ☐ Yes ☐ No	Spousal Life ☐ Yes ☐ No	Accidental Death & Dismemberment (premium waived for 24 months) ☐ Yes ☐ No

Section 5. APPOINTMENT OF BENEFICIARY(IES) (*use reverse of form or separate page if more space is needed)*

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.

Beneficiary designations will be the same on ALL OPP/OPPA Policies unless you indicate NO.
NO, please complete Section 6 instead. ☐ **NO**

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
Contact Information: Email:				Phone/Cell:	
Contact Information: Email:				Phone/Cell:	
Contact Information: Email:				Phone/Cell:	

***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*:**
☐ **Revocable*, I may change this beneficiary at any time.***

CONTINGENT BENEFICIARY(IES): if designating percentages amongst beneficiaries, 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
Contact Information: Email:				Phone/Cell:	
Contact Information: Email:				Phone/Cell:	

APPOINTMENT OF TRUSTEE: (only required if a named beneficiary is under (18) years of age)

You may wish to appoint a trustee/administrator by completing this section. If you are designating a trustee/administrator, it is recommended that 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, funds payable to the appointed 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 will release but not limited to the insurance company or the Administrators of the Plan from further liability.

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

Section 6. APPOINTMENT OF BENEFICIARY(IES) BY POLICY (*use reverse of form or separate page if more space is needed)*

1. OPPA Canada Life Dependent Life Insurance: $6,000 – Policy # 335354 – terminates at your age 65

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
Contact Information: Email:				Phone/Cell:	
Contact Information: Email:				Phone/Cell:	

***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*:**

☐ **Revocable*, I may change this beneficiary at any time.***

CONTINGENT BENEFICIARY(IES): if designating percentages amongst beneficiaries, 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
Contact Information: Email:				Phone/Cell:	
Contact Information: Email:				Phone/Cell:	

APPOINTMENT OF TRUSTEE: (only required if a named beneficiary is under (18) years of age)

You may wish to appoint a trustee/administrator by completing this section. If you are designating a trustee/administrator, it is recommended that you consult with a legal advisor and with any proposed trustee/administrator.

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

2. OPPA Canada Life Spousal Life Insurance: Policy # 335355
(reduces by 50% at age 65 and ends at your age 70)

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
Contact Information: Email:				Phone/Cell:	
Contact Information: Email:				Phone/Cell:	

***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*:**

☐ **Revocable*, I may change this beneficiary at any time.***

CONTINGENT BENEFICIARY(IES): if designating percentages amongst beneficiaries, 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
Contact Information: Email:				Phone/Cell:	
Contact Information: Email:				Phone/Cell:	

APPOINTMENT OF TRUSTEE: (only required if a named beneficiary is under (18) years of age)
You may wish to appoint a trustee/administrator by completing this section. If you are designating a trustee/administrator, it is recommended that 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, funds payable to the appointed 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 will release but not limited to the insurance company or the Administrators of the Plan from further liability.

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

3. OPPA Sutton AD&D: Policy # 056/022558A – valid for eligible surviving family members for 24 months

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
Contact Information: Email:				Phone/Cell:	
Contact Information: Email:				Phone/Cell:	
***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*:**					
☐ **Revocable*, I may change this beneficiary at any time.***					

CONTINGENT BENEFICIARY(IES): if designating percentages amongst beneficiaries, 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
Contact Information: Email:				Phone/Cell:	
Contact Information: Email:				Phone/Cell:	

APPOINTMENT OF TRUSTEE: (only required if a named beneficiary is under (18) years of age)
You may wish to appoint a trustee/administrator by completing this section. If you are designating a trustee/administrator, it is recommended that 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, funds payable to the appointed 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 will release but not limited to the insurance company 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 Digital 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 Surviving Members	New Applications for Surviving Members
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:

Member Name	Member WIN	OPPA Effective Date of Coverage (mm/dd/yyyy)

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