OPP ASSOCIATION GROUP INSURANCE – STUDENT CONFIRMATION FORM

Dependents 21 years of age but not yet 26 years of age enrolled in full-time post-secondary education

OPP Insured Benefits Policy #s: 044501/006772

Section 1. MEMBER INFORMATION:

OPP WIN: _____ **OPB Client ID:** _____

Last Name	**Legal First Name**	**Preferred Name**

Main Telephone Number: ☐ Cell ☐ Home ☐ Work

Personal E-mail Address:

SCHOOL YEAR: September 1, 20_____ to August 31, 20_____

Student updates are valid for one school year and must be updated annually. Students in Apprenticeship Programs are eligible only for the duration of in-class studies. Indicate only applicable in-class date range.

Section 2. DEPENDENT INFORMATION:

Full-Time Student Status	**Student Last year**	**Last Name**	**First Name**	**Date of Birth** (mm/dd/yyyy)
☐ Confirm ☐ Remove	☐ Yes ☐ No			
☐ Confirm ☐ Remove	☐ Yes ☐ No			
☐ Confirm ☐ Remove	☐ Yes ☐ No			

Section 3. OTHER BENEFITS: Please complete below if Student has additional coverage through other group plans.

Student Benefit Plan ☐	Plan/Carrier Name: _____ Policy #: _____ **Coverage includes**: ☐ Drugs ☐ Health ☐ Vision ☐ Dental ☐ Hospital
Other OPPA Member ☐	WIN / ID #: _____ *Other OPPA Member must complete Form 850 to update student status on their member profile*

Section 5. 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 6. AUTHORIZATION & DECLARATIONS

I authorize: 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)**

Return completed form to:

Email: targetforms@wlvinc.com or Fax: 416-740-2291
Target Benefit Administrators
5100 Orbitor Dr., Suite 204
Mississauga ON L4W 4Z4

For Inquiries:
Phone: 416-740-1335 or 1-888-660-6055
Email: target@wlvinc.com

OFFICE USE ONLY:

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