OPSEU Pension Trust | Fiducie du régime de retraite du SEFPO

LCBO EMPLOYEES CANADA LIFE INSURED BENEFITS FORM
(formerly Great-West Life)

OPSEU Pension Trust 1 Adelaide Street East, Suite 1200, Toronto, Ontario M5C 3A7
Telephone: 416-681-6100 Toll-free: 1-800-637-0024 Fax: 416-681-6175 **www.optrust.com**

Information is collected by OPTrust and coverage of benefits is provided through Canada Life.

PERSONAL INFORMATION

Last Name | **First Name and Initials** | Date of Birth (DD/MM/YYYY) D D M M Y Y Y Y | OPTrust ID Number

E-mail Address | Home Telephone Number | Business Telephone Number

Home Address: Number and Street | Apt. No.

City/Town | Province | Postal Code

Marital Status:
☐ Single ☐ Married ☐ Common-law ☐ Separated ☐ Divorced ☐ Widowed

COVERAGE

Type of Coverage
☐ Single ☐ Family

Retirement Effective Date (DD/MM/YYYY) D D M M Y Y Y Y

SPOUSAL INFORMATION

Last Name | **First Name and Initials** | Date of Birth (DD/MM/YYYY) D D M M Y Y Y Y

DEPENDANT INFORMATION

[1] Last Name | **First Name and Initials** | Date of Birth (DD/MM/YYYY) D D M M Y Y Y Y

☐ Dependant Under Age 21 ☐ Full Time Student Age 21-25 ☐ Disabled Age 21 or older

[2] Last Name | **First Name and Initials** | Date of Birth (DD/MM/YYYY) D D M M Y Y Y Y

☐ Dependant Under Age 21 ☐ Full Time Student Age 21-25 ☐ Disabled Age 21 or older

COORDINATION OF BENEFITS

Does your spouse have group insurance coverage under any other plan? ☐ Yes ☐ No
If "Yes", indicate if you or any member of your family are entitled to benefits under any other plan:

Medical
☐ Single ☐ Family ☐ Waived

Dental
☐ Single ☐ Family ☐ Waived

Vision/Hearing
☐ Single ☐ Family ☐ Waived

Name of Spouse's Insurance Carrier | Spouse's Plan Number | Spouse's ID Number

Keep a copy of this form for your records.

LIFE INSURANCE BENEFICIARY DESIGNATION

Life Insurance

Permanent & Seasonal	Waived $4,500**	Yes $4,500*
Permanent Part-Time & Casual	Waived $2,000**	Yes $2,000

* This amount is $5,000 initially and will be reduced to $4,500 on the October 1st coinciding with or following the date you retire.

** **Please Note:** If you decide to waive the life insurance, you must sign the waiver to opt out.

Last Name	**First Name and Initials**	Relationship to You

E-mail Address	Home Telephone Number	Business Telephone Number

Home Address: Number and Street	Apt. No.

City/Town	Province	Postal Code

You may change this beneficiary designation at any time upon completion of a new form or written notification.

PRIVACY

OPTrust and Canada Life Assurance Company recognize the importance of privacy. The personal information collected on this form is used to process your insured benefit changes. When you apply for coverage, Canada Life sets up a confidential file that is kept in the office of Canada Life or the office of an organization authorized by Canada Life. The information is required by OPTrust and Canada Life to: ensure your eligibility for insured benefits and the payment of claims is correct, respond to your questions, and comply with audit purposes. Access to your file is limited to OPTrust staff or persons authorized by us; Canada Life staff or persons authorized by Canada Life who require it to perform their duties; to persons who you have granted access and to persons authorized by law.

AUTHORIZATION AND DECLARATION

I hereby apply for benefits under the Province of Ontario Pensioner's Group Insurance Plan indicated in this application. I authorize:

- OPTrust to deduct from my pension and remit to the insurance provider the pensioner contribution required under the plan, if applicable;
- the use of my OPTrust ID where it is required to protect pensioner privacy and confidentiality in the administration of the plan;
- Canada Life any health care provider, OPTrust, other insurance or re-insurance companies, administrators or government benefits or other benefit programs, other organizations, or service providers working with Canada Life to exchange personal information, when necessary to determine my eligibility for coverage and to administer the plan.

If applying for coverage for my surviving spouse and/or dependant, I certify my insurable interests and confirm that I am authorized to act on their behalf. I agree that a photocopy or electronic copy of this Authorization and Declaration section is as valid as the original. I certify that the information given is true, correct and complete to the best of my knowledge.

Retiree's Signature	Date Signed (DD/MM/YYYY)
x Sign Here	D D M M Y Y Y Y