Ontario

Print Form

Group Insurance Application/Change Form OPSEU Fixed Term Employees Supplementary Health and Hospital Plan

Instructions

Please read carefully before completing the form.

Complete this form to apply for optional **Supplementary Health and Hospital Plan** (SHH), including the Catastrophic Drug Coverage (CDC), coverage under the Government of Ontario group insurance plan with Manulife Financial and to record allowable changes following initial enrolment.

Note: To apply for optional Dental Plan benefits you must complete another form, Group Insurance Application Form – OPSEU Fixed Term Employees Dental Plan, and submit it to The Canada Life Assurance Company.

Terms and Conditions

- You may apply **(one time option)** for SHH (with the CDC plan) with or without vision and hearing aids, coverage within 60 days of appointment to a fixed term position or within 31 days of a life event (marriage, or the birth or adoption of a child).
- You pay 100% of the monthly premium costs. The insurer, Manulife Financial, will collect premiums from your personal bank account via pre-authorized debit.
- Coverage will apply for the remaining duration of your fixed term contract and successive contracts not interrupted by a break in employment greater than 13 weeks. Coverage will not apply during a break in employment. **You must advise the carrier directly of any successive contracts.**

Enrolment

- Complete this form and select Single or Family coverage. Dependents must be identified if you require Family coverage.
- Complete the Manulife Financial's **Group Benefits ("Automatic Premium Withdrawal Application")** form (select the form under Group Insurance Application section on the InsideOPS > Benefits Policy > Forms web page) and provide an unsigned blank cheque marked “Void” to enable the carrier to deduct monthly premiums from your personal bank account.
- Mail the completed Group Insurance Application/Change form and Manulife Financial's Automatic Premium Withdrawal Application form to Manulife Financial.

Effective Date

Coverage is effective on the first of the month following receipt of your application form and Manulife Financial's Automatic Premium Withdrawal Application form by the insurer, for eligible expenses incurred on or after that date. Coverage will remain in effect for the term of your contract and any subsequent contract not interrupted by a break in employment greater than 13 weeks.

Changing Coverage

Allowable changes:

- Change from Single to Family coverage status within 31 days of a life event (marriage, birth or adoption of a child).
- Change from Family to Single coverage status when dependents are no longer “eligible” as defined.
- Terminate coverage or discontinue vision/hearing aids coverage as a result of a change from full-time to part-time contract.

Complete this form to indicate the changes to coverage status or to discontinue vision/hearing aids coverage, and mail it to Manulife Financial within 31 days of a life event.

Write to Manulife Financial to terminate SHH coverage.

The changes will apply for the remaining duration of your contract and any subsequent contract not interrupted by a break in employment greater than 13 weeks.

Termination of Coverage

Coverage will end on:

- The last day of the month in which your OPSEU fixed term employment ends; or
- The first day of the month in which you fail to make a premium payment. Collection procedures may apply to recover claim payments.

Coverage Reinstatement

- **Successive contracts not interrupted by a break in employment greater than 13 weeks:**
  - You must contact the insurer directly to advise of the contract extension and provide an updated Manulife Financial's Automatic Premium Withdrawal Application form.
  - You are not required to reapply for coverage.
  - The prior level of coverage will be reinstated effective the first of the month following your rehire date.
- **Successive contracts interrupted by a break in employment greater than 13 weeks:**
  - Prior coverage will not be reinstated.
  - You may elect to submit a new Group Insurance Application form within 31 days of your rehire date, as described above.

Coverage Reinstatement (continued)

- **Appointed to a fixed term contact in another bargaining group:**
  - You must complete a Group Insurance Application and a Pre-Authorized Debit (PAD) form to enroll in the policies for that group.
  - Premium rates differ by bargaining group.

Definitions

Dependent Child: An unmarried child who is:

- A natural or legally adopted child; or
- A child residing with you during the time of adoption probation; or
- A step-child residing in your household and for whom you are financially responsible; or
- A child residing with you and who is supported solely by you, and who is a relative by blood or marriage, or is under your legal guardianship.

In addition, the dependent child must be:

- under twenty-one (21) years of age; or twenty-one (21) years of age or older but not yet twenty-six (26) years of age and in full-time attendance at an accredited educational institution; or
- twenty-one (21) years of age or older who was insured under the plan prior to reaching age twenty-one (21) and who is mentally or physically disabled and financially dependent on the employee. Insurance carrier approval is required to validate dependent status.

Spouse: A person who is legally married to you, or if not legally married to you, cohabits with you in a continuing conjugal or same sex relationship.

Coordination of Benefits (COB): A group health insurance arrangement designed to eliminate duplicate claim payments and provide the sequence in which coverage applies when a person is insured under more than one insurance plan.

Forms, Signatures and Mailing

The Group Insurance Application Form is available online on InsideOPS > OSS Services (under OPS Bookmarks section) > Pay > Forms and Checklists (under Pay section) web page or on the Forms Repository.

Mail the completed form directly to Manulife Financial along with the Group Benefits Automatic Premium Withdrawal Application form indicating bank account details required to collect premiums. Keep copies for your records.

The Supplementary Health and Hospital Claim form is available on the InsideOPS > Benefits Policy > Forms page or on the Forms Repository.

For More Information

- **General Information** about your group insured benefits is available in the Benefits Guides web page for Regular staff in the “OPSEU Benefits Guide” PDF posted on the InsideOPS.
- **Enrolment, claims and premium payments**

  Please contact the insurer, Manulife Financial, directly at:

  Plan Member Administration
  Manulife Financial
  PO Box 11006, Stn Centre-Ville
  Montreal QC H3C 4T8

  Telephone: 1-800-268-6195

- **For general assistance:** Call OPS Service Centre
  InsideOPS: OPS Service Centre
  Web: Enterprise Virtual Assistant, EVA

	Telephone Number	Teletypewriter (TTY)
Within the GTA	416-915-7772	
Outside the GTA	1-888-99-OPSSC (1-888-996-7772)	1-866-310-7259

Note: The OPS Service Centre will not have information on your enrolment, claim status or premium payments.

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OPSEU Fixed Term Employees
Supplementary Health and Hospital Plan
Policy Number 15900

For inquiries, call the OPS Service Centre at: 416-915-7772 or 1-888-996-7772, TTY toll free 1-866-310-7259

☐ **New Application** (complete all sections)
☐ **Change** (complete sections only that are changing, name and WIN ID are mandatory) ► ☐ Change from Full-time to Part-time ☐ Change from Single/Family Coverage ☐ Add/Remove Dependents

Current Contract Begin Date (yyyy/mm/dd)
Current Contract End Date (yyyy/mm/dd)

1. Employee Information

☐ OPSEU Unified ☐ OPSEU Correctional

Last Name	First Name	Middle Initial

WIN ID	Ministry	Sex Designation	Date of Birth (yyyy/mm/dd)
		☐ M ☐ F ☐ X ☐ U	

Unit/Apt. Number	Street Number	Street Name

City/Town	Province	Postal Code

Home Telephone	Email Address

2. Group Insurance Benefits

Supplementary Health and Hospital Plan (including Catastrophic Drug Coverage)
☐ with Vision Care/Hearing Aids
☐ without Vision Care/Hearing Aids

Coverage Status
☐ Single
☐ Family (Insert dependent details below)

☐ Group Benefits Automatic Premium Withdrawal Application Form attached

Change To amend "Coverage Status" (above), following a Life Event (marriage, childbirth or adoption) and update "Dependent information"

Date of Change/Life Event (yyyy/mm/dd)	Date of Request (yyyy/mm/dd)

3. Dependent Information – See "Instructions" page for definitions of Spouse and Dependent Child (For additional dependents, attach separate sheet.)

Relationship	Add	Change	Remove	Last Name	First Name	Date of Birth (yyyy/mm/dd)	Sex Designation	If dependent child is 21 years of age or over: Full-time Student	If dependent child is 21 years of age or over: Disabled – (Approval from carrier required)
☐ Spouse	☐	☐	☐				☐ M ☐ F ☐ X ☐ U		
☐ Dependent Child	☐	☐	☐				☐ M ☐ F ☐ X ☐ U	☐ Yes ☐ No	☐ Yes ☐ No
☐ Dependent Child	☐	☐	☐				☐ M ☐ F ☐ X ☐ U	☐ Yes ☐ No	☐ Yes ☐ No
☐ Dependent Child	☐	☐	☐				☐ M ☐ F ☐ X ☐ U	☐ Yes ☐ No	☐ Yes ☐ No

4. Coordination of Benefits (COB)

Does your spouse have group insurance coverage under any other plan? (OPS or another employer) ☐ Yes ☐ No

If "Yes", indicate if you and any dependent children are entitled to benefits under those plans: ☐ Health ☐ Dental ☐ Vision/Hearing

Note: Contact the insurance carrier directly if you have a unique COB situation, e.g., dependent children covered by an ex-spouse.

5. Privacy

Personal information contained on this form is collected under the authority of the *Ministry of Government Services Act,* R.S.0. 1990, c M25. s.6(a), and is necessary to process your application since the government is self-insured, and the plan is internally administered. 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.

Questions about this collection should be directed to the OPS Service Centre (see contact information listed above) or write to the Director, Pay and Benefits Operations Branch, Pay and Benefits Services Division, Treasury Board Secretariat, c/o Macdonald Block Mail Facility, 77 Wellesley St W, PO Box 500, Toronto ON M7A 1N3.

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Last Name	First Name	Middle Initial

WIN ID	Ministry	Home Telephone

6. Authorization and Declarations

I hereby apply for group benefits or changes in benefits under the Province of Ontario Employees' Group Insurance Plan indicated in this application. I authorize:

- the insurer, Manulife Financial (Manulife), and my financial institution to deduct the required monthly premium directly from my bank account as indicated in the attached Group Benefits Automatic Premium Withdrawal Application OPSEU Fixed Term Manulife Form;
- the use of my WIN 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, or my spouse's, or my dependents' eligibility for coverage and to administer the plan;
- The insurer, Manulife Financial, and my employer to share information required to determine my eligibility, or my spouse's, or my dependents' eligibility for coverage under this plan.

I understand that the submission of fraudulent claims under the group insurance plan(s) that I am enrolled in is a criminal offence. Manulife and my employer take the submission of false or misrepresented claims seriously. I understand that a false or misrepresented claim submitted under a group insurance plan that I am enrolled in will be reported to my employer. I agree to refund any monies or overpayments owing to the insurance carrier(s) in accordance with the provisions of the group insurance benefits plan, and I authorize Manulife to deduct such monies from future claims' reimbursements. I authorize Manulife to release any evidence and information of an investigation related to a false or misrepresented claim to my employer. I understand that the submission of a false or misrepresented claim may result in disciplinary action by my employer including, but not limited to, termination of my employment. Manulife may refer any false or misrepresented claim to the law enforcement authorities.

I understand that I am responsible for the cost of the coverage I elected and if I do not have sufficient funds in my account to cover my premium payments, then I am required to contact the insurer, Manulife Financial, directly. Failure to make the premium payments will result in the termination of my coverage.

I understand that my enrolment information will be shared between my employer and the carriers to enable ongoing processing of my coverage.

If I am applying for coverage for my spouse and/or dependent(s), I certify my insurable interests and confirm that I am authorized to act on their behalf.

I agree that a signed photocopy or electronic copy of this Authorization and Declarations section of the Group Insurance Application/Change form is as valid as the original.

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

I agree to the terms and conditions herein and these terms and conditions shall remain in effect unless amended in writing by my employer.

Signature of Employee (mandatory)	**Date** (yyyy/mm/dd)
X	

Insurance Carrier Use Only

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

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