REMINDER: **You must be a member of RTOERO to enroll in the group insurance plan(s).**
If you are not a member, please first complete a membership application at rtoero.ca/join

RTO ERO Entente Insurance Application for Immediate Family

DO NOT FILL IN; FOR OFFICE USE ONLY / /

Personal information: (Please print all information)

Last Name (as it appears on your Provincial Health Card):		First Name (as it appears on your Provincial Health Card):	
Address – Street/Box/R.R.:			I have a government health plan (i.e. OHIP) ☐ Yes ☐ No
City:	Province:	Postal Code:	
Date of birth DD MM YYYY		Gender: As it appears on your Provincial Health Card	☐ Male ☐ Female
Primary phone:		Alternate phone:	
Personal email:		Alternate email:	

Membership status:

☐ Immediate family of a current RTOERO member – spouse, ex-spouse, child (including stepchildren and child-in-law), or grandchild

Specify RTOERO member's name:

Specify RTOERO member's certificate number:

Current/previous insurance information:

☐ I am uninsured, and have been uninsured for more than 60 days
Please visit: rtoero.ca/insurance/late-applicants
Note that these forms are reviewed by Securian Canada, our insurance underwriter, and processing may take 6 to 8 weeks

☐ I am currently enrolled in a group insurance plan, or was enrolled in a group insurance plan in the last 60 days.

If yes, please proceed with the section below:

Name of current/previous insurance company		☐ I am the policyholder ☐ My spouse or parent is the policyholder	
Policy number:		Identification number:	
Type of Coverage(s)	☐ Extended Health Care (EHC) Plan ☐ Hospital Plan ☐ Dental Plan	Level of Coverage	☐ Single ☐ Couple ☐ Family
Termination Date (if applicable)	DD MM YYYY		

Enrolment:

Dental Plan	Extended Health Care Plan	Hospital Plan
If yes: ☐ Single ☐ Couple ☐ Family	If yes: ☐ Single ☐ Couple ☐ Family	If yes: ☐ Single ☐ Couple ☐ Family
☐ I will not be enrolling in the dental plan	☐ I will not be enrolling in the EHC plan	☐ I will not be enrolling in the hospital plan

Premiums to be deducted from:

☐ My bank account (please attach a "VOID" cheque)

GROUP INSURANCE PLANS

Extended Health Care, Dental, Hospital and Convalescent Care are insured by Canadian Premier Life Insurance Company, operating under the brand name "Securian Canada", under a group insurance policy bearing contract numbers 141000, 141001, 141002.

TRAVEL INSURANCE BENEFITS

This insurance product is underwritten by Royal & Sun Alliance Insurance Company of Canada and is administered by Johnson.

You may contact the Insurer's authorized service administrator Johnson Inc. at 1-877-406-9007 in Canada and the U.S. or visit rtoero.johnson.ca.

Johnson Insurance is a tradename of Johnson Inc. ("Johnson"), a licensed insurance intermediary, and operates as Johnson Insurance Services in BC and Johnson Inc. in MB. Johnson and Royal & Sun Alliance Insurance Company of Canada share common ownership. Global Excel Management Inc. is the company appointed by Royal & Sun Alliance Insurance Company of Canada to provide medical assistance and claims services for Group Travel Insurance. Each insurer is legally and financially responsible only for the payment of the benefits, which they each insure. References to the "Insurers" in the Privacy Statement are to both Canadian Premier Life Insurance Company and Royal & Sun Alliance Insurance Company of Canada.

IF YOU HAVE SELECTED COUPLE OR FAMILY COVERAGE, PLEASE COMPLETE THE FOLLOWING:

Spouse/Partner

Last name:	First name:		
Covered by a government health plan (i.e. OHIP) ☐ Yes ☐ No	Date of birth: DD MM YYYY	Gender: As it appears on their Provincial Health Card	☐ Male ☐ Female

☐ Please allow my spouse to contact Johnson Inc. to obtain any information regarding this insurance. I agree to allow Johnson Inc. to release and discuss any and all aspects as it pertains to our insurance.

Dependent(s)

Last name:	First name:		
Covered by a government health plan (i.e. OHIP) ☐ Yes ☐ No	Date of birth: DD MM YYYY	Gender: As it appears on their Provincial Health Card	☐ Male ☐ Female
If over 21, indicate ☐ Student ☐ Functionally disabled		If student, name of school:	

Last name:	First name:		
Covered by a government health plan (i.e. OHIP) ☐ Yes ☐ No	Date of birth: DD MM YYYY	Gender: As it appears on their Provincial Health Card	☐ Male ☐ Female
If over 21, indicate ☐ Student ☐ Functionally disabled		If student, name of school:	

Coordination of benefits (if applicable)

Coordination of benefits may allow you to obtain a reimbursement of up to 100% of your eligible expenses. If you or any other member of your family is entitled to medical benefits under any other plan, please provide:

Name of insured family member:	Policy number:	Coverage ☐ Single ☐ Couple ☐ Family	Type of coverage ☐ Health ☐ Dental ☐ Hospital
Name of insurance company	Identification number:		

- **I understand that I must be a member of RTOERO to maintain the Entente Group Insurance Plans.**
- I hereby apply for coverage under the Entente Group Insurance Plans and authorize the deduction and remittance of premiums from my bank account for my contribution towards the cost of these benefit contracts. I have attached a VOID cheque. Premium is deducted one month in advance of the month of coverage.
- I acknowledge that in accordance with the below Privacy Statement, my personal information may be collected, used and disclosed in connection with the administration of the Entente Group Insurance Plans and RTOERO Master Policies, claims thereunder and other stated purposes among Johnson Inc. (Agent, Administrator and Claims Payor), the Insurer(s), the Travel Assistance Provider, RTOERO and any other applicable parties.
- I hereby certify that I have completed this application so that all statements made herein are true and correct in all respects and may be relied upon by RTOERO without further inquiry.
- I understand claim payments will be deposited directly into my bank account. I have attached a void cheque and provided an email address for notification of claim payments.

PRIVACY STATEMENT

I am authorized to disclose information about my spouse/partner and dependents for the purposes of determining their eligibility for coverage and enrolling them in Entente Group Insurance Benefits, including the related referral services. I authorize Johnson Inc. (Administrator and Claims Payor), Canadian Premier Life Insurance Company, CloudMD, as well as their agents and service providers, to collect, use and disclose relevant information about me, my spouse/partner and dependents needed for the purposes of enrolment, underwriting, adjudicating claims and the ongoing administration of the Entente Group Insurance Benefits and RTOERO Master Policies, including the related referral services, with each other, RTOERO and any other applicable parties.

Canadian Premier Life Insurance Company and Royal and Sun Alliance Insurance Company of Canada may collect, use, and disclose your personal information (including to and from your broker, its affiliates and service providers and organizations that may have referred you, and professional associations of which you may be a member) for purposes of quoting a premium, policy administration, improving customer experience, administering referral arrangements, and for other lawful purposes described in our Privacy Policy. For a copy of this document, please see: www.securiancanada.ca/privacy-code.html and www.rsagroup.ca/your privacy/privacy-policy.

Signature: * Date: * DD MM YYYY

Signature of spouse/partner (if applicable): * Date: * DD MM YYYY

PLEASE RETURN WITH YOUR RTOERO MEMBERSHIP APPLICATION TO:

RTOERO, 18 Spadina Road, Toronto ON M5R 2S7

416-962-9463 • 1-800-361-9888 • www.rtoero .ca • healthbenefits@rtoero.ca