OTIP RAEO ®

Application for Long Term Disability (LTD) Coverage Termination
OSSTF Provincial LTD Plan
Teachers Bargaining Unit Members

Basic Personal Information *(Must be completed)*

Name (Last, First and Middle Initial)		
Address (Number, Street and Apt.)		
City	Province	Postal Code
Home Telephone Number	Work Telephone Number	Employee Number
Email Address		Date of Birth *(mm/dd/yyyy)*
Employer		Plan number **50183** –

This form should be completed to terminate your LTD coverage and discontinue your LTD contribution deductions. Cancelling your LTD coverage due to an upcoming retirement (Scenario 2) should only be done after serious consideration of potential consequences.

There are **three** scenarios under which your LTD coverage can be terminated. Please check off the situation that applies to you and submit the required information as detailed below.

☐ **Scenario 1**	☐ **Scenario 2**	☐ **Scenario 3**
You are eligible for a 60% unreduced service pension now. **OR** You are eligible for a 60% unreduced service pension within the later of the next 110 working days or expiration of your sick leave to a maximum of 24 months.	Your scheduled retirement date is within the next 110 working days and you have notified your employer.	You have reached the end of the month in which you turned age 65. **OR** You will reach the end of the month in which you turn age 65 within the later of the next 110 working days or expiration of your sick leave to a maximum of 24 months.
A copy of your Ontario Teachers' Pension Plan statement is required, plus your current absence balance, if greater than 110 working days.	*A copy of your employer's acceptance of your retirement, plus a copy of your Ontario Teachers' Pension Plan statement is required.*	*A copy of your current absence balance, if greater than 110 working days.*

NOTE for Scenario 2:

- If your application is received **by** the 15th of the month, coverage will be cancelled effective on the 1st day of the following month.
- If your application is received **after** the 15th of the month, coverage will be cancelled effective the 1st day of the second month (subject to your board's payroll deadlines).

Authorization

In recognition of the documentation attached, I waive all rights of benefit or redress against the LTD plan, my employer, federation, or its officers, should I become ill or disabled after the effective date of this coverage termination and prior to my retirement from the board. I acknowledge that retroactive reinstatement of my LTD coverage is not permitted.

Member Signature X_____ **Date** *(mm/dd/yyyy)* _____

***** Return your completed form to your local OSSTF district office *****