OTIP
Group Life and Disability Claims
PO Box 218
Waterloo ON N2J 3Z9
1-800-267-6847 | www.otip.com

Member's LTD Claim Application

Clear text

INSTRUCTIONS FOR COMPLETION AND REQUIREMENTS

Please retain this portion for your information.

These instructions explain:

- How to apply for long term disability (LTD) benefits
- Which forms you must complete to notify OTIP Group Life and Disability Claims of your claim
- What will happen after you've submitted this application

We have also included a section on Frequently Asked Questions about this process.

You can also log in at: **www.otip.com/Group-Benefits/Administration** to learn more about your specific group LTD plan and coverage details. Your login and password can be obtained from your plan administrator.

To complete your Member's LTD Claim application, please submit the following forms to OTIP:

- ☐ Member's Statement (pages 7 - 10)
- ☐ Certification and Authorizations (pages 11, 13, 15)
- ☐ Consent to Disclose Personal Health Information (if applicable, page 17)
- ☐ Direct Deposit for Disability Benefit Payments (page 19)
- ☐ Attending Physician's Statement of Disability (completed by the physician)
- ☐ Proof of Age (see examples on page 7)

To prevent any delays, **all forms should be submitted to OTIP Group Life and Disability Claims at least 12 weeks before benefits are due**. In keeping with the terms of your group LTD plan, your claim must be received no later than six months following the date benefits became payable. OTIP will not be liable for claims received after this date or claims made more than six months after the plan termination date, if earlier.

Completed LTD claim applications should be sent to:

OTIP Group Life and Disability Claims
PO Box 218
Waterloo ON N2J 3Z9

Tel.: 1-800-267-6847
Fax: 1-877-205-6847

If you have any questions about your claim, please contact an OTIP representative at 1-800-267-6847.

A complete disability claim includes the following forms:

1. Member's Statement, Certification and Authorizations

To begin the claim submission process, you must complete and submit the attached **Member's Statement** and **Certification and Authorizations** pages. The authorizations allow OTIP to obtain more detailed information to establish your entitlement to benefits and must be signed before an assessment can begin.

2. Consent to Disclose Personal Health Information

The **Consent to Disclose Personal Health Information** form should only be completed if you have stopped working as a result of a mental and/or physical health condition. This consent form authorizes the release of mental and/or physical health information from a treating physician/facility.

3. Direct Deposit for Disability Benefit Payments

Please complete the **Direct Deposit for Disability Benefit Payments** form as payments will be deposited directly into your chequing/savings account if your claim is approved.

4. Qualifying Period Election (if applicable)

Under the terms of some group plans, you may have a choice related to your benefit start date (e.g. a specific number of days or the expiry of some or all of your sick leave credits). Once your board or local union has filled out their section of the **Qualifying Period Election** form, they will forward it to you for completion. This form is required for the assessment of your claim.

5. Attending Physician's Statement of Disability

As part of your application for long term disability (LTD) benefits, your treating physician(s) and/or specialist(s) must complete the Attending Physician's Statement of Disability.

Depending on your medical conditions(s), they will need to complete either the (1) **Mental Health Condition**, (2) **Physical Health Condition** or (3) both forms.

The completed form(s) must be submitted to OTIP Group Life and Disability Claims at least twelve weeks before your LTD benefits are due (e.g. the expiry of your sick leave).

In order to expedite the processing of your claim, it is necessary for your treating physician(s) and/or specialist(s) to provide as much detailed information as possible, such as a history of your condition, investigations, diagnostic findings, clinical course, treatment response and copies of any supplementary documentation, such as consultation reports, etc.

6. Plan Administrator's Statement

The **Plan Administrator's Statement** will be completed and submitted to OTIP by the plan administrator on your behalf. This statement confirms your effective date of insurance, job information, monthly earnings and other information needed to assess your claim.

Frequently Asked Questions

When does my claim assessment start?

Once we have received the Member's Statement, Certification and Authorizations, Attending Physician's Statement of Disability, and the Plan Administrator's Statement, your claim assessment will begin.

How will my claim be assessed?

Your claim forms will be reviewed by a Disability Analyst. A representative will contact you by telephone during the initial assessment to conduct an interview. The interview helps us obtain more detailed information about your job, education and employment history, medical history and current medical condition. Information will also be required about certain other sources of income that could affect the amount of your benefit. We can also address any questions or concerns you may have at that time. The interview not only minimizes claim submission requirements, but also prevents delays in the medical investigations. OTIP Group Life and Disability Claims representatives can then ask your attending physician all relevant medical questions at one time.

The questions asked during this interview may seem very detailed. We appreciate your patience and help in answering all questions as thoroughly as possible, as the information is needed for the assessment of your claim.

How will my medical information be reviewed?

During the initial assessment for benefits, OTIP Group Life and Disability Claims will review the Attending Physician's Statement of Disability and may contact the treating physician(s) for additional information.

If additional clarification is required from your physician, OTIP will make every effort to obtain medical information as quickly as possible. This information may be requested as soon as the claim interview has taken place. If we need assistance in obtaining additional information, we will contact you.

You are responsible for providing proof to OTIP that you are entitled to benefits, and this includes providing medical reports.

You are responsible for all expenses related to the completion of the Attending Physician's Statement of Disability and copies of additional medical reports provided.

Is there anything else I could provide to assist with the assessment of my claim?

If you have copies of pertinent medical information (e.g. consultation reports, test results, X-rays, etc.), please submit them to OTIP to expedite the assessment of your claim.

How is my claim evaluated?

Your claim will be evaluated based on whether your condition prevents you from performing the significant duties of your specific assignment.

What happens if my claim is approved?

If your claim is accepted according to the terms of your group LTD plan, a Disability Analyst will send you an approval letter and a detailed explanation of your benefits. Any contractual limitations that may apply to your claim will also be explained.

Frequently Asked Questions (continued)

What happens if my claim is denied?

If your claim is denied, a Disability Analyst will explain the reasons for denial. Appeal procedures will also be described, should you believe the initial assessment was incorrect or incomplete. OTIP Disability Service Representatives are available to assist you with the appeal process.

How is my benefit amount calculated?

Per diem policies

LTD benefits are paid monthly in accordance with the terms of your group LTD plan. During the first year of your claim, LTD benefits are paid on a daily (per diem) basis, with equal monthly payments until the end of August. The number of working days from the expiration of the qualifying period to the end of August is used in this calculation. Starting in September during the second year of benefits, and subject to continued medical evidence of disability, you may receive 12 equal, monthly payments per year.

12-month policies

LTD benefits are calculated by dividing your salary by 12 months, then multiplying this amount by your benefit level. Please consult your group LTD plan for information on your benefit level.

How will CPP disability/retirement benefits impact my monthly benefits?

Your group LTD plan provides for the integration of benefits when Canada Pension Plan (CPP) disability/retirement benefits are approved. Your group LTD plan directly deducts any benefits paid to you, as a contributor, from CPP. If OTIP asks you to apply for CPP disability/retirement benefits, you are required to submit an application.

What is involved in the assessment of my claim?

During the course of your claim, there are several types of investigations and information requests that may be necessary:

Requests for updated medical information

In order for OTIP to assess for ongoing eligibility, we will request updated medical information from your treatment providers (e.g. doctors, therapists, counsellors, etc.) as evidence of ongoing disability. In some situations, OTIP may request your assistance in obtaining medical information.

Independent medical examinations

In some instances, OTIP may require that you attend a medical or functional evaluation by an independent specialist. If we ask you to attend this type of appointment, costs associated with this appointment will be paid by OTIP.

Surveillance

In some instances, surveillance may be conducted. Surveillance is an investigative tool used for the purpose of comparing your observed activities to your medical limitations and restrictions.

Frequently Asked Questions (continued)

What is the "Reasonable and Customary Treatment" requirement?

Treatment must be prescribed and performed or supervised by your licenced physician or a certified specialist for the illness, injury or condition involved. For example, if your condition is cardiac in nature, you may be required to be under the care of a cardiologist. If you are disabled as a result of a mental health condition, you may be required to be under the care of a registered psychologist or psychiatrist.

Does OTIP offer return-to-work assistance?

OTIP's goal is to support you as you prepare to return to active employment as early as medically possible. You may be contacted by a Rehabilitation Consultant depending on the nature and severity of your condition.

Summary

Every claim is evaluated on its own merit in accordance with the terms of your group LTD plan.

If you have any questions about this information, please contact OTIP Group Life and Disability Claims at 1-800-267-6847.

MEMBER'S STATEMENT

Please complete the Member's Statement and Authorizations and mail to OTIP Group Life and Disability Claims.
(Please print)

Member Identification

1. Name: First _____ Middle Name _____ Last _____

   Home Address: _____

   City: _____ Province: _____ Postal Code: _____

   Telephone Number: _____ Mobile Number: _____

   Mailing Address: *(if different)* _____

   Email Address: _____

   City: _____ Province: _____ Postal Code: _____

2. Date of Birth: *(mm/dd//yyyy)* _____

   For proof of age, please provide a copy of one of the following: your birth certificate, driver's licence, baptismal certificate or passport.)

3. Sex at birth: ☐ Female ☐ Male

4. Occupation: ☐ Secondary ☐ Elementary ☐ Administration ☐ Clerical ☐ Trades

   ☐ Other _____

5. Affiliation: ☐ AEFO ☐ ETFO ☐ OECTA ☐ OSSTF ☐ OSSTF non-teaching ☐ CUPE

   ☐ Other _____

6. Ontario College of Teachers Registration Number *(if applicable)*: _____

7. What is your language preference? ☐ English ☐ French

Claim Information

1. School Board: _____ Grade Level (if applicable): _____

   Name of School: _____

   Specific assignment as of date last worked: _____

2. When did your health first become affected? *(mm/dd/yyyy)* _____

3. Date last worked on a regular basis before work absence began: *(mm/dd/yyyy)* _____

4. From what date has your condition prevented you from working (if different from #3):
   (mm/dd/yyyy) _____

MEMBER'S STATEMENT (CONTINUED)

5. Describe your present condition, its cause and history to date. If injured, please indicate the nature of the accident.

_____

_____

_____

_____

_____

6. Have you had this condition before? ☐ Yes ☐ No

   If yes, please explain: _____

_____

_____

_____

_____

7. Have you had any prior disability claims? ☐ Yes ☐ No

   If yes, name of insurer: _____

   Claim Number: _____

   Please provide dates: *(mm/dd/yyyy)* From: _____ To: _____

8. What treatment have you received (e.g. surgery, physiotherapy, medication, counselling)?

_____

_____

_____

_____

_____

9. Were you hospitalized for this condition? ☐ Yes ☐ No

   If yes, provide the date(s) *(mm/dd/yyyy)* and hospital name(s): _____

_____

_____

10. Name all your current treatment providers who have treated you for this condition (listing primary first).

Treatment Provider	Specialty	Address	Date of First Visit *(mm/dd/yyyy)*	Date of Last Visit *(mm/dd/yyyy)*

MEMBER'S STATEMENT (CONTINUED)

11. What changes, including improvements, have you noticed in your condition since the onset of treatment?

_____

_____

_____

_____

_____

12. What future treatment has been recommended?

_____

_____

_____

_____

13. Have you tried to return to work? ☐ Yes ☐ No

If yes, please provide dates: *(mm/dd/yyyy)* From: _____ To: _____

From: _____ To: _____

From: _____ To: _____

14. When do you expect to be able to return to: your own job? *(mm/dd/yyyy)* _____

Another job? *(mm/dd/yyyy)* _____

MEMBER'S STATEMENT (CONTINUED)

Financial

Have you applied for, or are you receiving, any of the following:

Income/Benefit	Date Applied *(mm/dd/yyyy)*	Date Started Receiving *(mm/dd/yyyy)*	Claim/Policy Number
Canada/Quebec Pension Plan Disability			
Canada/Quebec Pension Plan Retirement			
Employment Insurance			
Workplace Safety & Insurance Board (WSIB)			
Automobile Accident Benefits			

NOTE: Please provide copies of award/denial letters.

	Employment Start Date *(mm/dd/yyyy)*	Monthly Wages	Employment End Date *(mm/dd/yyyy)*
Wages from other employment			

Please specify source _____

Member's Name *(print clearly)*: _____

Member's Signature: _____ **Date: *(mm/dd/yyyy)*** _____

CERTIFICATION AND AUTHORIZATIONS - SECTION 1

I certify that the information in this form, and any further verbal or written statement provided by me in the future, is true and complete to the best of my knowledge. I understand that the Trustees of the Ontario Teachers Insurance Plan and OTIP/RAEO Benefits Incorporated ("OTIP") will investigate my claim and may require personal information about me, including information regarding my activities, income, employment, education and training, health, and medical history and treatment, including clinical notes (collectively referred to in this authorization as the "Information").

I authorize OTIP and its service providers to collect, use, maintain and disclose Information needed for the purposes of underwriting, benefits plan administration, audit, assessment, investigation and management of my claim, including independent medical assessments (collectively referred to in this authorization as the "Purposes") with any person or organization who has Information about me, including any plan administrator, plan sponsor, health care professional, health care institution, medical consultant, pharmacy, and any other medically-related facility, rehabilitation provider, insurer, reinsurer, investigative agency, administrator of government benefits or other benefit programs, and the Medical Information Bureau.

I authorize my employer and OTIP to collect, use, maintain and disclose Information with each other except for details related to diagnosis, medical history, or treatment, for the Purposes described above as well as for the purpose of planning and managing my rehabilitation and/or return to work.

I authorize OTIP to assess my Waiver of Premium benefits on my Group Life insurance, if applicable, using the Information provided for the Purposes of my claim for long term disability (LTD) benefits.

I agree that both my claim and my coverage may be denied or terminated as a result of my providing false, incomplete, misleading Information and/or if there is suspicion of fraud or plan abuse.

I agree to refund any monies that I may owe to OTIP in accordance with the provisions of the benefits plan with OTIP, and I authorize OTIP to deduct such monies from my benefits.

I consent to the disclosure by the Ontario Teachers' Pension Plan Board (OTPPB) or Ontario Municipal Employees Retirement System (OMERS) to OTIP of all personal information concerning my pension benefits in their custody or control, yearly and as required.

I agree that my consent is valid for the duration of my claim, but for the purposes of audit, for the duration of the plan.

I agree that a photocopy or electronic version of this authorization shall be as valid as the original.

I understand that OTIP's Privacy Policy is available at www.otip.com or by request.

Member's Name *(print clearly)*: _____

Member's Signature: _____ **Date: *(mm/dd/yyyy)*** _____

Any Information provided to or collected by OTIP in accordance with this authorization, will be kept in a benefits health file. Access to your Information will be limited to:

- OTIP employees, OTIP representatives, service providers, insurers and/or reinsurers (if applicable) in the performance of their jobs;
- Persons to whom you have granted access; and
- Persons authorized by law.

You have the right to request access to the Information in your file, and, where appropriate, to have any inaccurate information corrected.

Authorization and Consent to Communicate by Email (optional)

Member's Name *(print clearly)*: _____

Plan #: _____ **Claim #:** _____

Email Address: _____

Alternate Email Address: _____

Protecting your personal information and respecting your privacy is important to us which is why the Trustees of the Ontario Teachers Insurance Plan and OTIP/RAEO Benefits Incorporated ("OTIP") take precautions when communicating your personal information. We also believe it is important to inform you of the risks associated with certain communications such as email. Please read the below and sign this form if you understand the risks and agree to communicate via email.

While email is a quick and convenient way to communicate, we need to make you aware that the security of email cannot be guaranteed. By using this method, you understand that our email communications may include your personally-identifying information, including, but not limited to, sensitive personal information such as medical/health, employment and financial information.

The risks of using email include, but are not limited to:

- Email senders may accidently misaddress an email, resulting in it being sent to unintended or unknown recipients.
- Employers (e.g. school boards) and online services may have a legal right to monitor, inspect and/or keep emails that pass through their networks and systems.
- Email can be intercepted, altered, forwarded, stored and used without authorization or detection of the sender or recipient as it travels between internet service providers.
- Use of email to discuss sensitive information can increase the risk of such information being disclosed to third parties as emails are replied to and/or forwarded.
- Email is indelible – even after the sender and recipient have deleted their copies, back-up copies may exist on a computer or in cyber-space.

By consenting to use email communications to discuss matters related to your claim, you agree to:

- Inform us of any changes to your email address(es).
- Inform us should you wish to withdraw your consent for the use of email communications by sending an email from an email address above or alternate written withdrawal.
- Hold OTIP and its authorized service providers harmless of all losses, expenses, damages and costs related to electronic communications.

I understand and accept the risks associated with email communications and consent and authorize OTIP to use email when communicating with me regarding my claim.

Member's Name *(print clearly)*: _____

Member's Signature: _____ **Date: *(mm/dd/yyyy)*** _____

Authorization to Release Information to Third Parties

The Trustees of the Ontario Teachers Insurance Plan and OTIP/RAEO Benefits Incorporated ("OTIP") will only disclose your personal information with the organizations or persons noted above for the Purposes. If you consent to OTIP disclosing information related to your claim with other individuals (e.g. spouse, relative, affiliate representative), please complete the following:

I authorize and consent to OTIP disclosing any information related to my claim for long term disability benefits with the following individuals:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Should I wish OTIP to not disclose information to the individuals noted above, I understand I am responsible to notify OTIP in writing of this change.

Member's Name *(print clearly)*: _____

Member's Signature: _____ **Date: *(mm/dd/yyyy)*** _____

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Consent to Disclose Personal Health Information

MEMBER INFORMATION AND AUTHORIZATION

Name: First _____ Middle Name _____ Last _____

Home Address: _____

City: _____ Province: _____ Postal Code: _____

Telephone Number: _____ Mobile Number: _____

Date of Birth: *(mm/dd/yyyy)* _____

Authorization:

I, _____ , hereby authorize _____

(Member's full name) *(Name of physician/treatment facility)*

to disclose to the Trustees of the Ontario Teachers Insurance Plan and OTIP/RAEO Benefits Incorporated ("OTIP"):

☐ my personal health information

OR

☐ the personal health information of: _____

(Name of person for whom you are the substitute decision-maker)*

**A substitute decision-maker is a person authorized under the Personal Health Information Protection Act (PHIPA) to consent, on behalf of an individual, to disclose personal health information about the individual.*

Consisting of:

Consultation reports, clinical records, investigative findings, hospital/clinical notes, medical reports, progress reports, narrative reports, medical opinions, X-rays, reports of diagnostic tests, and any other medical/health information in connection with my physical and mental health.

For the purposes of:

A medical file review and benefits plan administration to determine eligibility for disability benefits.

I understand the purpose for disclosing my personal health information to the person/organization noted above. I understand that I can withdraw my consent for OTIP to use any of the information contained herein at any time; however, as a result, OTIP may be unable to fully assess my claim for benefits and benefits may be denied. I agree that my consent is valid for the duration of my claim. I agree that a photocopy or electronic version of this authorization shall be as valid as the original.

Member's Signature: _____ **Date:** ***(mm/dd/yyyy)*** _____

Witness's Name: _____ **Signature:** _____

This form complies with the Personal Health Information Protection Act (PHIPA).

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Direct Deposit for Disability Benefit Payments

OTIP's Direct Deposit service is a convenient, secure, no-charge way to deposit your disability benefit payments directly into your chequing/savings account. Direct Deposit can help make your money management more convenient and assures you receive your funds on time without disruptions or delays due to mail service.

How will I know when the deposit has been made?

Long term disability (LTD) payments will be deposited into your banking account by the end of each month. The deposit will appear in your account either as **OTIP** or **OTIP/RAEO**. If there are any re-calculations to your LTD payments, an explanation of benefits or an electronic fund transfer (EFT) statement will be sent to you at that time.

What if I change my bank account?

Notify OTIP Group Life and Disability Claims in writing of your new account and include your long term disability claim number. Enclose a cheque marked "VOID" or provide your new account number and the name and address of your financial institution.

To enrol in OTIP's Direct Deposit service, complete this form and return it to OTIP at the address above or by confidential fax to 1-877-205-6847.

MEMBER INFORMATION

Name: First _____ Middle Name _____ Last _____

Home Address: _____

City: _____ Province: _____ Postal Code: _____

Telephone Number: _____ Mobile Number: _____

Date of Birth: *(mm/dd/yyyy)* _____

Claim Number: _____

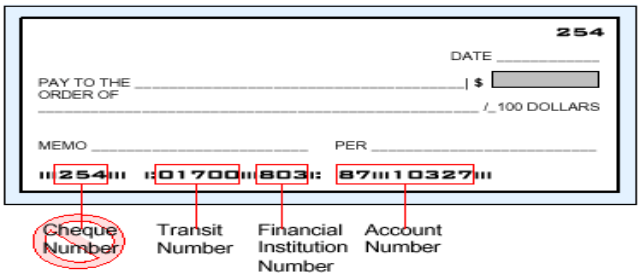
FINANCIAL ACCOUNT INFORMATION AND AUTHORIZATION

Authorization:

I hereby request and authorize the Trustees of the Ontario Teachers Insurance Plan and OTIP/RAEO Benefits Incorporated ("OTIP") to deposit long term disability benefit payments into the account below. This authorization will remain in effect until cancelled by me in writing. I understand that I must notify OTIP Group Life and Disability Claims in writing if I change or close my account. Your financial information will be maintained securely and used for the purpose of electronically depositing your disability benefit payments into your account. (NOTE: For Canadian financial institutions only.)

Deposit start date into the account below: *(mm/dd/yyyy)*: _____

Enclose a cheque marked "VOID" or contact your financial institution for the required account information below.



Transit Number

Financial Institution Number

Account Number

Account Type ☐ Chequing ☐ Savings

Signature of Account holder(s) _____ **Date** *(mm/dd/yyyy)* _____