APPLICATION FOR EXTENDED HEALTH CARE AND DENTAL PLANS

RETIRED TEACHERS' ASSOCIATION OF MANITOBA

If you have any questions about the Plan, or need assistance completing your application form, please contact the Plan Administrator, Johnson Inc., at 1.877.989.2600 (Option #2) or via email at pbservicewest@johnson.ca.

1. APPLICATION INFORMATION – Please print clearly

First Name(s)	Last Name	Gender ☐ Male ☐ Female	Date of Birth DD MM YYYY
Address (including Apartment/Unit Number)			
City/Town	Province/Territory	Postal Code	Telephone Number ( )
Provincial Health Registration #	Personal Health ID #	Email Address	
I am eligible to receive a pension through the Teachers' Retirement Allowances Fund (TRAF) ☐ Yes ☐ No	TRAF Pension #	TRAF Pension Effective Date DD MM YYYY	

I am a member of RTAM: ☐ Yes ☐ No **If no, please complete the form on the RTAM website: www.rtam.mb.ca**

2. PLAN INFORMATION

EXTENDED HEALTH CARE (EHC) PLAN:

I wish to enrol in the EHC Plan	Indicate status of coverage required
☐ No ☐ Core ☐ Enhanced	☐ Single ☐ Family

Are you enrolled in your Province's Pharmacare Plan**? (Applicable to Provinces/Territories where a Pharmacare Program exists.)
☐ Yes ☐ No

**If no, please contact your Province's Pharmacare to enroll in their program as it is a requirement for the RTAM Plan.

NOTE: *Current Core Plan members requiring more than the $900 Drug Plan maximum can upgrade to the Enhanced Drug Plan at the beginning of a policy year, April 1st. Once you opt into the Enhanced Plan, you must remain in the Plan for 24 months.*

DENTAL PLAN:

I wish to enrol in the Dental Plan	Indicate status of coverage required
☐ Yes ☐ No	☐ Single ☐ Family

Check here if you are maintaining coverage in **addition** to this Plan ☐ Are you the ☐ Member OR ☐ Spouse

NOTE: *Coverage for this Plan will become effective the 1st day of the month following the date of receipt of this form.*

Insurance Company _____ Policy Number _____

If you are **not** maintaining additional coverage, when transferring from an employer sponsored group insurance plan or your spouse's employer sponsored group insurance plan, **you must** provide the termination date (in space below). Coverage for this Plan is effective the day after your or your spouse's plan terminates.

Termination Date of Your board benefits or Your Spouse's group benefits plan DD MM YYYY

NOTE: *Those with current group benefits coverage may apply within **60 days** of losing existing employer coverage. After 60 days of prior plan termination, evidence of insurability is required.*

IMPORTANT: YOU MUST COMPLETE AND SIGN SECTION 4 ON THE REVERSE FOR COVERAGE TO BE IN FORCE

Please direct all inquiries about the application, policies, authorization for premium deductions or any written notice of change or cancellation to the Plan Administrator, Johnson Inc. at 1-877-989-2600 (Option #2) or pbservicewest@johnson.ca.

If you have selected Family coverage, please provide Spousal/Dependent Details below:

First Name(s)		Last Name	Gender ☐ Male ☐ Female
Provincial Health Registration #:	Personal Health ID #:	Date of Birth: DD MM YYYY	Dependents age 21+: ☐ Full Time Student ☐ Disabled
First Name(s)		Last Name	Gender ☐ Male ☐ Female
Provincial Health Registration #:	Personal Health ID #:	Date of Birth: DD MM YYYY	Dependents age 21+: ☐ Full Time Student ☐ Disabled

For additional Dependents, please provide information on a separate page.

3. MONTHLY PREMIUM PAYMENT

NOTE: Deductions are withdrawn one month in advance. For example, the August 5th deduction pays for September coverage.

Please select one of the following:

☐ **I am a FULL RTAM Member.** I am in receipt of TRAF Pension No. _____ (found on the top right corner of any letter from TRAF) and authorize TRAF to deduct from my pension payment the amount of my insurance premium (including mid-term adjustments and arrears) payable to Johnson Inc. Bank deduction option is also available for TRAF Pension recipients (please attach a cheque marked "VOID").

☐ **I am a FULL RTAM Member** who does not receive a TRAF Pension. I have enclosed a **sample cheque marked "VOID"**. I authorize Johnson Inc., the Plan Administrator, to make monthly deductions (including mid-term adjustments and arrears) from the bank, trust company or credit union account shown on the cheque.

☐ **I am an ASSOCIATE RTAM Member.** I have enclosed a **sample cheque marked "VOID"**. I authorize Johnson Inc., the Plan Administrator, to make monthly deductions (including mid-term adjustments and arrears) from the bank, trust company or credit union account shown on the cheque.

4. CONSENT AND SIGNATURE

I hereby certify that I am a Member in good standing with the Retired Teachers' Association of Manitoba and my eligibility ceases upon termination of my RTAM membership.

I authorize that my premium for this insurance, including any mid policy year adjustments, arrears and renewals, be deducted in monthly amounts due on or after this date of application. I understand that my policy will be automatically cancelled should Johnson Inc. receive two or more Non-Sufficient Funds (NSF) notices on my account.

I recognize that the RTAM EHC Plans require members to be enrolled in their Provincial Pharmacare Program. If you are not already enrolled in your Province's Pharmacare Program, please contact Pharmacare as soon as possible.

I understand that EHC and Dental coverage will begin on the day after my current group benefits terminate OR, if maintaining coverage under my current group plan, on the 1st of the month following the date of receipt of application. If applying as a late applicant, I understand EHC coverage will become effective the date the completed application is approved by the Insurer.

I also understand that unless I advise Johnson Inc. in writing to the contrary, the coverage I have selected **will remain in effect for each policy year thereafte**r. Johnson Inc. will provide me with notification of my renewal before the beginning of each subsequent policy year, which is April 1st.

I authorize my "Group", the Retired Teachers' Association of Manitoba, my "Plan Administrator" Johnson Inc., and my "Insurer" Desjardins Financial Security (collectively, the "Providers") to collect, use, maintain and disclose my financial, medical and other personal information, including the information relating to any spouse or dependent who may be the subject of this application (the "Information"), for the purposes of the Extended Health Care and/or Dental Plans (the "Plans") administration and audit and the assessment, investigation, management, processing and/or underwriting of this application and any claims under the Plans (collectively, the "Purposes"). **I authorize** any person with information, including any medical and health professional, facilities or providers, professional regulatory bodies, any employer, group plan administrator, insurer investigative agency and any administrators of other benefits programs to collect, use, maintain and exchange this information with each other and with the Providers and any replacement Plan Administrator, Insurer, Administrator approved by my Group, for the Purposes. **I understand** that any coverage will not become effective until approved by the Providers. **I authorize** the use of my Provincial health number and any Group member ID for the purposes of identification and administration.

_____ _____

Signature of Applicant **Date**

_____ _____

Signature of Spouse (if Family coverage selected) **Date**

PLEASE FORWARD YOUR APPLICATION TO:

JOHNSON INC.
GROUP BENEFITS
#100, 17203 – 103 Avenue NW
Edmonton, Alberta T5S 1J4
Fax: (780) 420-6082