



# APPLICATION FOR RTAM HEALTH AND DENTAL PLANS

Please complete and return to Johnson Inc. in the postage-paid envelope provided.

## 1. PLEASE PRINT - APPLICANT INFORMATION

First Name(s)		Last Name	
Address - (Including Apt. / Unit No.)			
City/Town	Province/Territory	Postal Code	Telephone Number ( ) -
Date of Birth Day Month Year	Provincial Health (Personal) Plan Number	E-mail Address	
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Name of School Board at Retirement/Employer at Retirement		

## 2. PLAN SELECTION

Extended Health Care Plan	Dental Plan
I wish to enrol in Option: A <input type="checkbox"/> Yes <input type="checkbox"/> No B <input type="checkbox"/> Yes <input type="checkbox"/> No C <input type="checkbox"/> Yes <input type="checkbox"/> No	I wish to enrol in this plan: <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please indicate status of coverage required: <input type="checkbox"/> Single <input type="checkbox"/> Couple <input type="checkbox"/> Family	If yes, please indicate status of coverage required: <input type="checkbox"/> Single <input type="checkbox"/> Couple <input type="checkbox"/> Family
Are you enrolling in Emergency Medical Travel Plan: <input type="checkbox"/> Yes <input type="checkbox"/> No	Termination date of board benefits or spouse's group plan: Day Month Year
*If yes, please complete the Application for Emergency Medical Travel Plan.	
Termination date of board benefits or spouse's group plan: Day Month Year	

## 3. IF TRANSFERRING FROM YOUR SPOUSES GROUP INSURANCE PLAN, PLEASE COMPLETE:

Insurance Company \_\_\_\_\_ Policy Number \_\_\_\_\_ Date of Termination \_\_\_\_\_

## 4. IF YOU HAVE SELECTED FAMILY COVERAGE, PLEASE COMPLETE THE FOLLOWING:

Relationship to Participant	FIRST NAME	LAST NAME	SEX M/F	PERSONAL PROVINCIAL HEALTH NUMBER	DATE OF BIRTH D M Y	IF CHILDREN OVER 21 INDICATE IF FULL-TIME STUDENT OR HANDICAPPED
Spouse					/ /	
Dependent					/ /	
Dependent					/ /	
If child(ren) over 21, name of school(s): (Proof Required)					/ /	

**IMPORTANT - YOU MUST COMPLETE AND SIGN SECTION 5 ON THE REVERSE FOR COVERAGE TO BE IN FORCE.**

**OT** in receipt of 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.

