Clear Form

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Group Benefits Application

For internal use only

Contract # _____

Applicant Information

Legal Company Name

_____

Effective Date Requested

(Month) _____ (Day) 01 (Year) _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Administrator Name: _____ Title: _____

Phone: _____ Fax: _____ Email: _____

Executive Contact: _____ Title: _____

Phone: _____ Fax: _____ Email: _____

Applicant's Declaration

The applicant hereby declares that, to the best of the applicant's knowledge, the statements and answers contained herein are full, complete and true as of the date hereof and expressly agrees and acknowledges that: (1) such statements and answers will form part of the group contract or policy issued by The Benefits Trust and/or its insurance partners; (2) the benefits coverage under the group contract or policy shall become effective in accordance with and subject to the terms of the group contract or policy issued to the applicant; (3) in no case shall coverage become effective until the later of the payment of the initial deposit and approval of this application by The Benefits Trust; and (4) The Benefits Trust will not be liable to the applicant or to any of the applicant's employees or any other persons proposed to be covered under this application until it has been approved. The attached Schedule of Benefits forms part of the application.

The initial deposit of $ _____ is included with this application. Negotiation of the deposit will not, of itself, constitute approval of the application. The deposit will be applied against the first month's contribution statement from The Benefits Trust.

Dated at _____ this _____ day of _____, _____

by _____ _____
(Applicant's signature) (Title)

_____
(Applicant's printed name)

Broker / Agent Information and Declaration

Broker / Agent Name: _____ Title: _____

Broker / Agent Corporate Name: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Phone: _____ Fax: _____ Email: _____

I have advised the applicant: (1) not to terminate any existing coverage until notice has been received in writing that the coverage being applied for is accepted; and (2) no coverage is in existence until this application is approved by The Benefits Trust.

By: _____ Date: _____

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Agent Number: _____

Commission Scale: _____

Business Information

Nature of Business: _____

Number of Years in Operation: _____ Ownership: ☐ Corporation ☐ Partnership ☐ Sole Proprietorship

Name(s) of Owner(s) if Partnership or Sole Proprietorship: _____

Prior Insurer(s): _____ Prior Insurer(s) Since: (Month) _____ (Year) _____

Benefits Insured: _____

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Benefits Insured: _____

Confirmation of Employee Status

Are all Employees covered by WSIB? ☐ Yes ☐ No

If No, provide names of those not covered by WSIB and reason for non-coverage:

_____

_____

Are any Employees currently Off Work due to Sickness or Disability: ☐ Yes ☐ No

If Yes, provide name, date of disability, nature of disability, age, sex, benefit amount, expected date of return to work, and status of life premium waiver for each employee:

_____

_____

Plan Guidelines

- Eligible Employees must work a minimum of 24 hours per week.
- Waiting period for Full Time Employees is three (3) months unless waived by the Employer upon enrollment. Waiting period does not apply to Eligible Employees currently on payroll as of effective date of benefits plan.
- Health Care Spending Account contributions must be fully employer funded in accordance with Revenue Canada guidelines.
- All changes to plan design will come into effect on the plan anniversary date.
- The benefit year will be the 12 month period following the effective date.
- Life Insurance & Accidental Death & Dismemberment Insurance reduce by 50% at age 65. Benefit terminates at age 70. Critical Illness Insurance terminates at age 65. Long Term Disability Insurance terminates at age 65. Extended Health Care, Dental Care and Health Care Spending Account coverage terminates at age 70.

Schedule of Benefits

Class	Class Description

Mandatory Benefits

Extended Health Care

- Prescription Drug Benefit
- Semi-Private Hospital Room
- Out of Country Emergency Care

Benefit terminates at age 70.

Optional Benefits

Life Insurance ($25,000)

☐ Yes ☐ No

Life Insurance reduces by 50% at age 65. Benefit terminates at age 70.

Accidental Death & Dismemberment ($25,000)

☐ Yes ☐ No

Accidental Death & Dismemberment Insurance reduces by 50% at age 65. Benefit terminates at age 70.

Dependent Life Insurance ($10,000 spouse, $5,000 child)

☐ Yes ☐ No

Benefit terminates at employee age 70.

Critical Illness ($25,000)

☐ Yes ☐ No

Benefit terminates at age 65.

Dental Care

☐ Yes ☐ No

Benefit terminates at age 70.

Health Care Spending Account

☐ Yes ☐ No

Benefit Amount: _____

- Adjudicated as a Balance Carry Forward plan. Any unused HCSA balance from one year may be carried forward to the next year. Any balance carried forward that has not been spent by the end of the next year will revert to the company.
- Benefit will be pro-rated for new employees upon eligibility, based on the number of full months worked in the benefit year.
- Changes in benefit amount due to seniority take effect at the start of the next benefit year, and will not be pro-rated over the year.
- Benefit terminates at age 70.

Long Term Disability (subject to quotation prior to application)

☐ Yes ☐ No

66.7% of monthly earnings. Maximum and NEM as quoted by insurer.

Disability Definition: Two year own occupation
Elimination Period: 119 days
CPP/QPP Offsets: Primary
Benefit payable to age 65
Pre-Existing Condition: 3/12
Non-taxable
Benefits terminates at age 65

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☐ Yes ☐ No

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☐ Yes ☐ No

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Dental Care

☐ Yes ☐ No

Benefit terminates at age 70.

Health Care Spending Account

☐ Yes ☐ No

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