UNIGROUP INC.

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GROUP INSURANCE MASTER APPLICATION

850 – 10655 Southport Rd. S.W.
Calgary, AB T2W 4Y1
(403) 297-0250 / 1-800-292-9066

850 – 10655 Southport Rd. S.W.
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(403) 297-0250 / 1-800-292-9066

GROUP CLIENT INFORMATION

Applicant's Name: (Full Legal Name) _____

Business Address: _____

City: _____ Province: _____ Postal Code: _____

Mailing Address (if different from above)_____

City: _____ Province: _____ Postal Code: _____

Telephone: (____) _____ Fax: (____) _____

Contact Person: _____ Title: _____

Email Address: _____

Nature of Industry: _____

❑ New Group ❑ Amendment Policy No(s). _____
_____

GROUP POLICY INFORMATION

Effective Date: _____ Renewal Date: _____

Language Preference: ❑ English ❑ French

Total number of employees to be eligible as of policy effective date: _____

Total number of employees on payroll as of policy effective date: _____

Please describe any participants excluded from coverage under this policy: _____

_____

_____

SUBSIDIARY/AFFILIATED FIRMS INFORMATION

Please list subsidiaries/affiliated firms to be insured and identified in the policy.

1. _____
2. _____
3. _____
4. _____
5. _____

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BILLING DIVISION STRUCTURE/INFORMATION

(Complete if more than one division)

Division	Class	Division Name / Class Description	Division - Nature of Industry

If Address for the divisions/classes are different, please complete this section

Division/Class: _____

Street Address: _____

City: _____ Province: _____ Postal Code: _____

Telephone :(____) _____ Ext: _____ Fax: (____) _____

Contact Person: _____ Title: _____

Email Address: _____

Division/Class: _____

Street Address: _____

City: _____ Province: _____ Postal Code: _____

Telephone :(____) _____ Ext: _____ Fax: (____) _____

Contact Person: _____ Title: _____

Email Address: _____

Division/Class: _____

Street Address: _____

City: _____ Province: _____ Postal Code: _____

Telephone :(____) _____ Ext: _____ Fax: (____) _____

Contact Person: _____ Title: _____

Email Address: _____

Division/Class: _____

Street Address: _____

City: _____ Province: _____ Postal Code: _____

Telephone :(____) _____ Ext: _____ Fax: (____) _____

Contact Person: _____ Title: _____

Email Address: _____

_____
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ADMINISTRATION INFORMATION

Previous carrier: _____

Number of years in-force: _____ Previous policy number(s): _____

Termination date (of previous carrier): _____

If there was LTD and / or CI coverage with the prior carrier and LTD and / or CI is included with this group, it is imperative that the client keep a copy of the LTD and / or CI contract from their most recent carrier, as it will be used to help with assessment of the pre-existing limitation on any claims that occur in the first two years of the plan.

Hours normally worked: ❑ 40 ❑ 37.5 ❑ 35 ❑ Other: _____

The minimum number of weekly hours a participant must work in order to be eligible for coverage is:

❑ 20 hours ❑ 24 hours ❑ other (greater than 20 hours), please specify: _____

Are seasonal employees to be insured for coverage under this plan? ❑ Yes ❑ No

NOTE: Seasonal employees must work a minimum number of cumulative months (out of 12 months) to be eligible for coverage. Certain restrictions in coverage will also apply during lay-off.

Are independent contractors to be insured for coverage under this plan? ❑ Yes ❑ No

NOTE: Certain restrictions in coverage to independent contractors will apply.

Are all participants who are eligible for STD and/or LTD covered by a Worker's Compensation or a similar plan? ❑ Yes ❑ No

If "no", please provide details. _____

Are any of the benefits union negotiated? ❑ Yes ❑ No

If "Yes", please attach a copy of the Union Agreement.

WAITING PERIOD :

- For all existing employees (**hired prior to the effective date** of this policy): _____ months*
- For all new employees (**hired on or after the effective date** of this policy: _____ months

**** NOTE: waiting period should be the same as for new employees, as all administration systems apply the waiting period based on the employee's date of hire/full time employment. This is important for employees still within the waiting period at time coverage takes effect / or transfers.***

Is the plan a condition of employment? ❑ Yes ❑ No

Employee Contributions: ❑ All Classes or Specify Class Name: _____

Employee Contribution Level Options:

1. _____% of overall premium
2. _____% by benefit
3. _____ Flat $ amount by benefit

Life / AD&D	_____	LTD	_____	Health	_____
Dependent Life	_____	STD	_____	Dental	_____

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SPECIAL HANDLING OF SPECIFIED PARTICIPANTS

Are there any participants expected to be absent from work because of injury or sickness on the plan's effective date?

❑ Yes ❑ No

If yes, complete the following:

Participant's Name	Date Sickness Began or Injuries Occurred	Nature of Absence
		❑ STD ❑ LTD ❑Mat Leave ❑ Leave without pay ❑ Temporary lay-off ❑ Strike, lock-out
		❑ STD ❑ LTD ❑Mat Leave ❑ Leave without pay ❑ Temporary lay-off ❑ Strike, lock-out
		❑ STD ❑ LTD ❑Mat Leave ❑ Leave without pay ❑ Temporary lay-off ❑ Strike, lock-out
		❑ STD ❑ LTD ❑Mat Leave ❑ Leave without pay ❑ Temporary lay-off ❑ Strike, lock-out
		❑ STD ❑ LTD ❑Mat Leave ❑ Leave without pay ❑ Temporary lay-off ❑ Strike, lock-out
		❑ STD ❑ LTD ❑Mat Leave ❑ Leave without pay ❑ Temporary lay-off ❑ Strike, lock-out

PREMIUM INFORMATION (completed by Unigroup Inc.)

Payment Enclosed: ❑ Yes ❑ No If yes: $_____

(If split by division, please provide split)

Division #: _____ Premium: _____ Tax: _____ Total: _____

Division #: _____ Premium: _____ Tax: _____ Total: _____

Division #: _____ Premium: _____ Tax: _____ Total: _____

Division #: _____ Premium: _____ Tax: _____ Total: _____

Total: $_____ **Total: _____**

_____
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SALES TAX INFORMATION

1. Does the policyholder have ANY employees in a province that charges Retail Sales Tax?

   ❑ Yes ❑ No (If Yes, complete sections A and B)

SECTION A

Policyholders are required to pay Ontario Retail Sales Tax on all their premiums unless they have employees who are exempt from the application of this tax.

Application of this tax is exempt for premiums on employees who are:

1. Not ordinarily resident in province where RST applies, or
2. Indians ordinarily resident on a reserve.

If the policyholder has employees who are exempt, please complete the **Retail Sales Tax Blanket Purchase Exemption Certificate**. The Ministry of Revenue requires that Unigroup Inc. have documentation on file confirming this exemption.

NOTE: If, in the future, the policyholder's answers to these questions change, Unigroup Inc. must be notified.

REMIT RETAIL SALES TAX ON EMPLOYEE CONTRIBUTIONS TO THE GOVERNMENT

Date: _____

Business name: _____

Pursuant to Regulation 1013 made under the Retail Sales Tax Act, we will be remitting the Retail Sales Tax collected from our employees in connection with insurance provided to them under Policy No. _____, or in connection with benefits provided under a benefits plan administered by Unigroup Inc. under Contract No. _____.

Such election will apply for the duration of the policy referred to above during which time Unigroup Inc. will not be responsible for any Provincial Sales Tax collected but not remitted to the appropriate Minister.

_____

Signature

_____

Name

_____

Title

_____

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SECTION B

RETAIL SALES TAX
BLANKET PURCHASE EXEMPTION CERTIFICATE

Business name: _____

Business address: _____

RST Vendor Permit No. (if applicable): _____

Unigroup Inc. Policy/Contract No.: _____

Description of Policy or Benefit Plan: _____

Under the provisions of the Retail Sales Tax Act, the above-named business claims exemption from Retail Sales Tax on insurance premiums paid: (check appropriate box)

- ❑ By an employer under a contract of insurance or benefits plan in respect of employees who ordinarily works outside of the province where RST applies or whose salary is ordinarily paid outside the province where RST applies or in respect of former employees who are no longer resident in the province where RST applies.
- ❑ Under a contract of insurance or benefits plan in respect of other individuals who are not ordinarily resident of the province where RST applies.
- ❑ Under a contract of insurance or benefits plan where the person whose risk is covered is a Status Indian ordinarily resident on a Reserve.

_____
Signature of Authorized Person

_____ _____
Name of Authorized Person (please print) Date

_____
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BENEFIT ADMINISTRATION

		Class 1	Class 2	Class 3	Class 4
❑ **Employee Basic Life**	Insurer:	_____	_____	_____	_____
Rate: $ _____/ 1,000	Benefit Amount:	❑ Flat Amount $_____ ❑ Times Earnings _____ (1, 2 or 3)	❑ Flat Amount $_____ ❑ Times Earnings _____ (1, 2 or 3)	❑ Flat Amount $_____ ❑ Times Earnings _____ (1, 2 or 3)	❑ Flat Amount $_____ ❑ Times Earnings _____ (1, 2 or 3)
	Non-Evidence Maximum:	$_____	$_____	$_____	$_____
	Overall Maximum:	$_____	$_____	$_____	$_____
	Reduction:	❑ None ❑ 50% at age 65	❑ None ❑ 50% at age 65	❑ None ❑ 50% at age 65	❑ None ❑ 50% at age 65
	Termination:	❑ Age 65 or earlier retirement ❑ Age 70 or earlier retirement	❑ Age 65 or earlier retirement ❑ Age 70 or earlier retirement	❑ Age 65 or earlier retirement ❑ Age 70 or earlier retirement	❑ Age 65 or earlier retirement ❑ Age 70 or earlier retirement

		Class 1	Class 2	Class 3	Class 4
❑ **Accidental Death & Dismemberment**	Insurer:	_____	_____	_____	_____
Rate: $ _____/ 1,000	Benefit Amount:	❑ Matches Life ❑ Flat Amount $_____ ❑ Times Earnings _____ (1, 2 or 3)	❑ Matches Life ❑ Flat Amount $_____ ❑ Times Earnings _____ (1, 2 or 3)	❑ Matches Life ❑ Flat Amount $_____ ❑ Times Earnings _____ (1, 2 or 3)	❑ Matches Life ❑ Flat Amount $_____ ❑ Times Earnings _____ (1, 2 or 3)
	Non-Evidence Maximum:	$_____	$_____	$_____	$_____
	Overall Maximum:	$_____	$_____	$_____	$_____
	Reduction:	❑ None ❑ 50% at age 65	❑ None ❑ 50% at age 65	❑ None ❑ 50% at age 65	❑ None ❑ 50% at age 65
	Termination:	❑ Age 65 or earlier retirement ❑ Age 70 or earlier retirement	❑ Age 65 or earlier retirement ❑ Age 70 or earlier retirement	❑ Age 65 or earlier retirement ❑ Age 70 or earlier retirement	❑ Age 65 or earlier retirement ❑ Age 70 or earlier retirement

		Class 1	Class 2	Class 3	Class 4
❑ **Dependent Life**	Insurer:	_____	_____	_____	_____
Rate: $ _____/ unit	Benefit Amount: - Spouse	❑ $5,000 ❑ $10,000 ❑ $15,000 ❑ $20,000	❑ $5,000 ❑ $10,000 ❑ $15,000 ❑ $20,000	❑ $5,000 ❑ $10,000 ❑ $15,000 ❑ $20,000	❑ $5,000 ❑ $10,000 ❑ $15,000 ❑ $20,000
	- Child(ren) NB: Coverage is from live birth.	❑ $2,500 ❑ $5,000 ❑ $10,000	❑ $2,500 ❑ $5,000 ❑ $10,000	❑ $2,500 ❑ $5,000 ❑ $10,000	❑ $2,500 ❑ $5,000 ❑ $10,000
	Termination:	❑ Age 65 or earlier retirement ❑ Age 70 or earlier retirement	❑ Age 65 or earlier retirement ❑ Age 70 or earlier retirement	❑ Age 65 or earlier retirement ❑ Age 70 or earlier retirement	❑ Age 65 or earlier retirement ❑ Age 70 or earlier retirement

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BENEFIT ADMINISTRATION

		Class 1	Class 2	Class 3	Class 4
❑ **Short Term Disability**	Insurer:	_____	_____	_____	_____
Rate: $ _____/ 10	Benefit Amount:	_____ % of weekly earnings	_____ % of weekly earnings	_____ % of weekly earnings	_____ % of weekly earnings
	Non-Evidence Maximum:	$_____ Per week	$_____ Per week	$_____ Per week	$_____ Per week
	Overall Maximum:	$_____ Per week	$_____ Per week	$_____ Per week	$_____ Per week
	Benefit Start Dates:	❑ 1-4-1 ❑ 1-8-1 ❑ 15-15-15	❑ 1-4-1 ❑ 1-8-1 ❑ 15-15-15	❑ 1-4-1 ❑ 1-8-1 ❑ 15-15-15	❑ 1-4-1 ❑ 1-8-1 ❑ 15-15-15
		1st or 15th day accident / 4, 8, 15th day sickness / 1st or 15th day if hospitalized			
	Benefit Period:	❑ 17 weeks ❑ 26 weeks	❑ 17 weeks ❑ 26 weeks	❑ 17 weeks ❑ 26 weeks	❑ 17 weeks ❑ 26 weeks
	Tax Status:	❑ Taxable ❑ Non-Taxable	❑ Taxable ❑ Non-Taxable	❑ Taxable ❑ Non-Taxable	❑ Taxable ❑ Non-Taxable

		Class 1	Class 2	Class 3	Class 4
❑ **Long Term Disability**	Insurer:	_____	_____	_____	_____
Rate: $ _____/ 100	Benefit Amount:	_____ % of monthly earnings OR _____% of 1st $_____ + _____% of the next $_____ + _____% of the balance	_____ % of monthly earnings OR _____% of 1st $_____ + _____% of the next $_____ + _____% of the balance	_____ % of monthly earnings OR _____% of 1st $_____ + _____% of the next $_____ + _____% of the balance	_____ % of monthly earnings OR _____% of 1st $_____ + _____% of the next $_____ + _____% of the balance
	Non-Evidence Maximum:	$_____ Per month	$_____ Per month	$_____ Per month	$_____ Per month
	Overall Maximum:	$_____ Per month	$_____ Per month	$_____ Per month	$_____ Per month
	Elimination Period:	❑ 17 weeks ❑ 26 weeks	❑ 17 weeks ❑ 26 weeks	❑ 17 weeks ❑ 26 weeks	❑ 17 weeks ❑ 26 weeks
	Occupation Definition:	❑ 2 years ❑ 5 years	❑ 2 years ❑ 5 years	❑ 2 years ❑ 5 years	❑ 2 years ❑ 5 years
	Benefit Period:	❑ 2 years ❑ 5 years ❑ To age 65	❑ 2 years ❑ 5 years ❑ To age 65	❑ 2 years ❑ 5 years ❑ To age 65	❑ 2 years ❑ 5 years ❑ To age 65
	Tax Status:	❑ Taxable ❑ Non-Taxable	❑ Taxable ❑ Non-Taxable	❑ Taxable ❑ Non-Taxable	❑ Taxable ❑ Non-Taxable
	3 Month Survivor Benefits Included:	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No

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BENEFIT ADMINISTRATION

		Class 1	Class 2	Class 3	Class 4
❑ **Extended Health Care**	Insurer:	_____	_____	_____	_____
Rate: $ _____/ Single $ _____/ Family	Deductible:	❑ Nil ❑ $____ single / $_____ family ❑ $____dispensing fee on Drugs	❑ Nil ❑ $____ single / $_____ family ❑ $____dispensing fee on Drugs	❑ Nil ❑ $____ single / $_____ family ❑ $____dispensing fee on Drugs	❑ Nil ❑ $____ single / $_____ family ❑ $____dispensing fee on Drugs
	Overall Maximums:	Out-of-Country (O.O.C.) Referral $ _____ Out-of-Country (O.O.C.) Emergency $ _____	Out-of-Country Referral $ _____ Out-of-Country Emergency $ _____	Out-of-Country Referral $ _____ Out-of-Country Emergency $ _____	Out-of-Country Referral $ _____ Out-of-Country Emergency $ _____
	Hospital Reimbursement Level:	❑ 100% ❑ 80% ❑ Other: - _____%	❑ 100% ❑ 80% ❑ Other: - _____%	❑ 100% ❑ 80% ❑ Other: - _____%	❑ 100% ❑ 80% ❑ Other: - _____%
	Drug Reimbursement Level:	❑ 100% ❑ 80% ❑ Other: - _____%	❑ 100% ❑ 80% ❑ Other: - _____%	❑ 100% ❑ 80% ❑ Other: - _____%	❑ 100% ❑ 80% ❑ Other: - _____%
	O.O.C. Emergency Reimbursement Level:	❑ 100% ❑ 80% ❑ Other: - _____%	❑ 100% ❑ 80% ❑ Other: - _____%	❑ 100% ❑ 80% ❑ Other: - _____%	❑ 100% ❑ 80% ❑ Other: - _____%
	O.O.C. Referral Reimbursement Level:	❑ 50% ❑ Other _____	❑ 50% ❑ Other _____	❑ 50% ❑ Other _____	❑ 50% ❑ Other _____
	All Other Expenses Reimbursement Level:	❑ 100% ❑ 80% ❑ Other: - _____%	❑ 100% ❑ 80% ❑ Other: - _____%	❑ 100% ❑ 80% ❑ Other: - _____%	❑ 100% ❑ 80% ❑ Other: - _____%
	Drug Plan Type:	❑ Reimbursement ❑ Direct Card ❑ "Generic"	❑ Reimbursement ❑ Direct Card ❑ "Generic"	❑ Reimbursement ❑ Direct Card ❑ "Generic"	❑ Reimbursement ❑ Direct Card ❑ "Generic"
	Drug Plan Annual Maximum:	❑ Unlimited ❑ $_____	❑ Unlimited ❑ $_____	❑ Unlimited ❑ $_____	❑ Unlimited ❑ $_____
	Drug Coverage Includes:	❑ Smoking Cessation products ❑ Infertility drugs ❑ Erectile dysfunction ❑ Anti-obesity ❑ Preventative immunization vaccines ❑ Drugs requiring injections including vitamins, insulin & allergy extracts	❑ Smoking Cessation products ❑ Infertility drugs ❑ Erectile dysfunction ❑ Anti-obesity ❑ Preventative immunization vaccines ❑ Drugs requiring injections including vitamins, insulin & allergy extracts	❑ Smoking Cessation products ❑ Infertility drugs ❑ Erectile dysfunction ❑ Anti-obesity ❑ Preventative immunization vaccines ❑ Drugs requiring injections including vitamins, insulin & allergy extracts	❑ Smoking Cessation products ❑ Infertility drugs ❑ Erectile dysfunction ❑ Anti-obesity ❑ Preventative immunization vaccines ❑ Drugs requiring injections including vitamins, insulin & allergy extracts

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	Hospital Benefit:	❑ Private ❑ Semi-private	❑ Private ❑ Semi-private	❑ Private ❑ Semi-private	❑ Private ❑ Semi-private
	Paramedical Maximum:	$ _____	$ _____	$ _____	$ _____
	Select practitioners to be covered:	❑ Physiotherapists & ❑ Physical Rehabilitation therapists ❑ Massage therapists & ❑ Orthotherapists ❑ Speech therapists, ❑ Audiologists, ❑ Chiropractors, ❑ Osteopaths, ❑ Psychologists, ❑ Social Workers, ❑ Naturopaths, ❑ Chiropodists or ❑ Podiatrists ❑ Acupuncturists ❑ Occupational Therapists ❑ Dieticians			
	Orthopaedic Shoes Maximum:	$ _____	$ _____	$ _____	$ _____
	Foot Orthotics Maximum:	$ _____	$ _____	$ _____	$ _____
	Hearing Aids Maximum:	$_____ per ____ months	$_____ per ____ months	$_____ per ____ months	$_____ per ____ months
	Private Duty Nursing Maximum:	$ _____	$ _____	$ _____	$ _____
	Eye Exams:	$ _____ maximum ❑ per 24 months all; or ❑ per 24 mos. Adults / 12 mos. Children	$ _____ maximum ❑ per 24 months all; or ❑ per 24 mos. Adults / 12 mos. Children	$ _____ maximum ❑ per 24 months all; or ❑ per 24 mos. Adults / 12 mos. Children	$ _____ maximum ❑ per 24 months all; or ❑ per 24 mos. Adults / 12 mos. Children
	Out-of-Country Included:	❑ Yes _____ days ❑ No	❑ Yes _____ days ❑ No	❑ Yes _____ days ❑ No	❑ Yes _____ days ❑ No
	24 Months Survivor Benefit included:	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No

		Class 1	Class 2	Class 3	Class 4
❑ **Vision Care**	Insurer:	_____	_____	_____	_____
Rate: $ _____/ Single $ _____/ Family	Deductible:	❑ Nil ❑ $____ single / $_____ family	❑ Nil ❑ $____ single / $_____ family	❑ Nil ❑ $____ single / $_____ family	❑ Nil ❑ $____ single / $_____ family
	Reimbursement Level:	❑ 100% ❑ 80% ❑ Other: - _____%	❑ 100% ❑ 80% ❑ Other: - _____%	❑ 100% ❑ 80% ❑ Other: - _____%	❑ 100% ❑ 80% ❑ Other: - _____%
	Benefit Maximum:	$ _____	$ _____	$ _____	$ _____
	Frequency:	❑ once per 24 months for all ❑ once per 24 months – adults ❑ once per 12 months – child(ren)	❑ once per 24 months for all ❑ once per 24 months – adults ❑ once per 12 months – child(ren)	❑ once per 24 months for all ❑ once per 24 months – adults ❑ once per 12 months – child(ren)	❑ once per 24 months for all ❑ once per 24 months – adults ❑ once per 12 months – child(ren)

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BENEFIT ADMINISTRATION

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❑ **Dental Care**	Insurer:	_____	_____	_____	_____
Rate: $ _____/ Single $ _____/ Family	Deductible:	❑ Nil ❑ $____ single / $_____ family	❑ Nil ❑ $____ single / $_____ family	❑ Nil ❑ $____ single / $_____ family	❑ Nil ❑ $____ single / $_____ family
	Reimbursement Level: NB: Orthodontic coverage is to age 19 only	❑ Preventive _____% ❑ Basic _____% ❑ Major _____% ❑ Orthodontic _____%	❑ Preventive _____% ❑ Basic _____% ❑ Major _____% ❑ Orthodontic _____%	❑ Preventive _____% ❑ Basic _____% ❑ Major _____% ❑ Orthodontic _____%	❑ Preventive _____% ❑ Basic _____% ❑ Major _____% ❑ Orthodontic _____%
	Benefit Maximum:	**Preventive:** ❑ unlimited, or ❑ $ _____ annually ❑ combined with Basic **Basic:** ❑ unlimited, or ❑ $ _____ annually ❑ combined with Preventive **Major:** ❑ $ _____ annually ❑ combined with Preventive & Basic **Orthodontic:** ❑ $ _____ lifetime	**Preventive:** ❑ unlimited, or ❑ $ _____ annually ❑ combined with Basic **Basic:** ❑ unlimited, or ❑ $ _____ annually ❑ combined with Preventive **Major:** ❑ $ _____ annually ❑ combined with Preventive & Basic **Orthodontic:** ❑ $ _____ lifetime	**Preventive:** ❑ unlimited, or ❑ $ _____ annually ❑ combined with Basic **Basic:** ❑ unlimited, or ❑ $ _____ annually ❑ combined with Preventive **Major:** ❑ $ _____ annually ❑ combined with Preventive & Basic **Orthodontic:** ❑ $ _____ lifetime	**Preventive:** ❑ unlimited, or ❑ $ _____ annually ❑ combined with Basic **Basic:** ❑ unlimited, or ❑ $ _____ annually ❑ combined with Preventive **Major:** ❑ $ _____ annually ❑ combined with Preventive & Basic **Orthodontic:** ❑ $ _____ lifetime
	Frequency:	❑ once/6 months ❑ once/9 months ❑ once/12 months	❑ once/6 months ❑ once/9 months ❑ once/12 months	❑ once/6 months ❑ once/9 months ❑ once/12 months	❑ once/6 months ❑ once/9 months ❑ once/12 months
	Current Fee Guide:	❑ Yes ❑ No, specify year _____	❑ Yes ❑ No, specify year _____	❑ Yes ❑ No, specify year _____	❑ Yes ❑ No, specify year _____
	Specialists included:	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
	24 Months Survivor Benefits Included:	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No

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BENEFIT ADMINISTRATION

		Class 1	Class 2	Class 3	Class 4
❑ **Critical Illness**	Insurer:	_____	_____	_____	_____
Rate: $ _____/ 1000	Deductible:	Nil	Nil	Nil	Nil
	Reimbursement Level:	100 %	100 %	100 %	100 %
	Benefit Maximum:	$ _____	$ _____	$ _____	$ _____
	Coverage:	Includes 21 diseases such as Heart Attack, Cancer, Parkinson's, MS, Alzheimer's, Major Organ Transplant & Kidney Failure	Includes 21 diseases such as Heart Attack, Cancer, Parkinson's, MS, Alzheimer's, Major Organ Transplant & Kidney Failure	Includes 21 diseases such as Heart Attack, Cancer, Parkinson's, MS, Alzheimer's, Major Organ Transplant & Kidney Failure	Includes 21 diseases such as Heart Attack, Cancer, Parkinson's, MS, Alzheimer's, Major Organ Transplant & Kidney Failure
	Conversion:	Available	Available	Available	Available
	Termination:	❑ Age 65 or earlier retirement ❑ Age 70 or earlier retirement	❑ Age 65 or earlier retirement ❑ Age 70 or earlier retirement	❑ Age 65 or earlier retirement ❑ Age 70 or earlier retirement	❑ Age 65 or earlier retirement ❑ Age 70 or earlier retirement

		Class 1	Class 2	Class 3	Class 4
❑ **Employee Assistance Plan**	Insurer:	_____	_____	_____	_____
Rate: ❑ $ ____	Coverage:	❑ Telephonic ❑ Full Benefits	❑ Telephonic ❑ Full Benefits	❑ Telephonic ❑ Full Benefits	❑ Telephonic ❑ Full Benefits
	Reimbursement Level:	100 %	100 %	100 %	100 %
	Termination:	❑ Age 65 or earlier retirement ❑ Age 70 or earlier retirement	❑ Age 65 or earlier retirement ❑ Age 70 or earlier retirement	❑ Age 65 or earlier retirement ❑ Age 70 or earlier retirement	❑ Age 65 or earlier retirement ❑ Age 70 or earlier retirement

		Class 1	Class 2	Class 3	Class 4
❑ **WorldCare**	Insurer:	_____	_____	_____	_____
Rate: ❑ $ ____	Coverage:	2nd Opinion includes independent review, diagnosis and treatment recommendations	2nd Opinion includes independent review, diagnosis and treatment recommendations	2nd Opinion includes independent review, diagnosis and treatment recommendations	2nd Opinion includes independent review, diagnosis and treatment recommendations
	Termination:	❑ Age 65 or earlier retirement ❑ Age 70 or earlier retirement	❑ Age 65 or earlier retirement ❑ Age 70 or earlier retirement	❑ Age 65 or earlier retirement ❑ Age 70 or earlier retirement	❑ Age 65 or earlier retirement ❑ Age 70 or earlier retirement

_____
Client to initial above

850 – 10655 Southport Rd. S.W.
Calgary, AB T2W 4Y1
(403) 297-0250 / 1-800-292-9066

BROKER INFORMATION

Broker: _____

License No.: _____

Commission Rate: _____

Street Address: _____

City: _____ Province: _____ Postal Code: _____

Telephone: (_____) _____ Fax: (_____) _____

Email Address: _____

_____
Client to initial above

850 – 10655 Southport Rd. S.W.
Calgary, AB T2W 4Y1
(403) 297-0250 / 1-800-292-9066

To apply for Group Insurance:

We, the previously mentioned: _____ (the applicant) apply to Unigroup Inc. for the group insurance described in this application. We acknowledge and agree that the attached quotation and Appendixes form a part of this application.

We agree that no insurance will take effect until all of the following conditions have been met:

1. This application must be accepted and the effective date approved by Unigroup Inc. at its Head Office;
2. A binder premium must be paid; and
3. The minimum participation requirements must be met.

We request that insurance be effective: _____.

WE DECLARE that all statements, representations and answers made in this application are a consideration for and a basis of the contract(s) of insurance between us and Unigroup Inc. We declare these statements, representations and answers to be true, full and complete. We agree that no other statement, representation or information will be binding upon or affect the rights of Unigroup Inc. We agree to give Unigroup Inc., on request, full information on each participant insured or eligible for insurance, including information required for assessment of claims.

Please complete the date and signature section below.

❑ ***To amend your Group Insurance:***

We, the previously mentioned: _____ (the applicant) apply to Unigroup Inc. for amendment of our Group Policy Number _____.

We request that insurance be effective: _____.

We acknowledge and agree that the attached quotation forms a part of this application.

We AGREE that:

1. Increases in benefits only take effect when a participant is actively at work. If a dependant is in hospital confined on the date an increase would otherwise take effect, it will not take effect until the date of discharge from hospital.
2. A policy amendment is valid and takes effect as of the effective date approved by Unigroup Inc. ONLY IF:
   a) It is made according to the application; and
   b) It is signed by an executive officer of Unigroup Inc. and by or for the actuary of Unigroup Inc.

WE DECLARE that all statements, representations and answers made in this application are a consideration for and a basis of the requested amendment(s). We declare these statements, representations and answers to be true, full and complete. We agree that no other statement, representation or information will be binding upon or affect the rights of Unigroup Inc. We agree to give Unigroup Inc., on request, full information on each participant insured or eligible for insurance, including information required for assessment of claims.

Please complete the date and signature section below.

Signature Section:

Dated at _____ this _____ day of _____ 20 _____

Applicant _____

_____	_____
(PRINT NAME)	(PRINT TITLE)
_____	_____
(PRODUCER'S SIGNATURE)	(APPLICANT'S SIGNATURE)

_____
Client to initial above