



**EMPLOYER APPLICATION
GROUP BENEFITS PROGRAM**

GENERAL INFORMATION

Applicant: (full legal name):

Legal Status:

Partnership Corporation Other, please specify: _____ Date Established: _____

Business Address:

Street: _____ City: _____ Province: _____ Postal Code: _____

Group Contact:

Nature of Business:

Phone Number: (_____) _____ - _____ Ext. # _____ Fax Number: (_____) _____ - _____

Email Address: _____

EMPLOYEE ELIGIBILITY / PARTICIPATION / WAITING PERIOD

Total Number of Eligible Employees: _____ Are all employees covered by WCB? Yes No

Number of Employees covered for Extended Health and/or Dental: _____ Single _____ Family _____ Waived

All Employees must work a minimum of 24 hours per week to be eligible for coverage under this plan.

Employee pays 100% of Disability premium (to result in tax-free plan)? Yes No

Employer requests the following Cost Sharing Option: Employer pays _____% / Employee pays _____% (minimum of 50%)

Is this plan replacing an existing group benefit plan? Yes No

If yes: Insurance company name _____ Policy No. _____

Effective date for new eligible employees is first day of the month following _____ continuous months of employment.
(Employers may make written requests for waiting period to be waived for key employees.)

PLAN DESIGN REQUESTED

Life Insurance:	Flat Amount: \$ <u>100,000</u>
AD & D:	Flat Amount: \$ <u>100,000</u>
Dependent Life:	\$ 10,000 Spouse / \$5 ,000 Dependent Children
Critical Illness:	Employees Only for Level \$ <u>25,000</u>
Extended Health:	Nil Deductible Reimbursement – Hospital & Out-of-Province/Country - <u>100</u> %; All Other Expenses – <u>80</u> %
Prescription Drugs:	Dispensing Fee Deductible Reimbursement - <u>100</u> % Drug Card (Generic)
Vision Care:	Nil Deductible Reimbursement – <u>80</u> % \$ <u>250</u> Benefit (per 24 Months)
Dental:	Nil Deductible Reimbursement - <u>100</u> % Basic <u>Unlimited</u> annual maximum/person
Employee Assistance Program:	Included

Select which Plan Option (or both) is desired (minimum 3 employees/participants to be eligible):

Optional Weekly Indemnity: 66.67% of weekly earnings Maximum: \$500 NEM: \$ _____
Payment Qualifying Period: 1st Day Hospital/Accident; 8th Day Sickness;
Benefit Duration: 17Weeks

Optional Long Term Disability: 66.67% of monthly earnings Maximum: \$4,000 NEM: \$ _____
Payment Qualifying Period: 120 day elimination
Benefits Payable to Age 65 Definition of Disability 2 Yr. Own Occupation

NOT ACTIVELY AT WORK

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

Yes No

Employee's Name	Date Sickness Began or Injuries Occurred	Nature of Absence *

* Nature of Absence: Please indicate S – STD; L – LTD, ML – Mat Leave; LWOP – Leave without pay; TL – Temporary lay-off; ST – Strike or lock-out; V - Vacation

REQUESTED EFFECTIVE DATE / PREMIUM RECEIPT

Application is hereby made for a Group Benefits Plan in accordance with the Master Policy issued to the Association. It is understood that the agreement will not provide coverage prior to the first of the month following approval. A deposit equal to one month's premium is payable to Canadian Benefit Administrators (CBA).

Requested effective date for coverage is (mm) _____ (dd) _____, (yyyy) 20_____.

Any existing coverage should not be cancelled until this application is approved.

EMPLOYER PARTICIPATION AGREEMENT

In connection with this application, the employer:

- a) declares that to the best of his knowledge, all statements, representations and answers contained herein are full, complete and true as of the date of this application;
- b) understands that coverage will not become effective until the 1st of the month following approval and acceptance by the insurer(s) underwriting the master group contract(s) and once accepted, this application will form part of the master group contract(s);
- c) acknowledges that the CBA is the Plan Administrator in all matters pertaining to monthly premium billings, premium payments, employee enrolment, group records, employee records, insurers' reports and client service;
- d) understands and accepts that the authorized signature on behalf of the Employer confirms knowledge of and consent by its proprietor, partners, directors, and/or principals that he/she/they are responsible for and personally guarantee payment to the CBA of all premiums arising from this contract;
- e) acknowledges that certain contractual and administrative conditions exist with respect to employer eligibility, employee eligibility, employee participation, waiting period, effective dates of coverage, evidence of insurability, pre-existing conditions and eligibility for late applicants and agree to accept and adhere to these conditions: and
- f) agrees to abide by and be subject to all the terms, conditions, rules, regulation, policy particulars, definitions and other provisions as set out in the Master Policy, including any additions or amendments thereto, copies of which are available.

Dated at _____ in the province of _____, this _____ day of _____, 20_____.

Authorized signature of Employer

Please Print Name and Title

Name of Firm(s) / Producer(s):	Split:	Signature(s) of Licensed Producer(s):
<u>Unigroup Inc.</u>	_____ %	_____
_____	_____ %	_____



For TPA Administration purposes only.

Client #: _____

Location #: _____

Request for Pre-authorized Withdrawal for _____
(Company Name here)

Authorization Agreement

I hereby authorize **Canadian Benefit Administrators Ltd.** to make automatic withdrawals for my insurance premiums, from my account at the financial institution named below.

I understand that premiums will be withdrawn on the first Thursday of each month.

Further, I understand that **Canadian Benefit Administrators Ltd.** will terminate my pre-authorized payment plan if any withdrawal is reversed by my financial institution.

This will authorize **Canadian Benefit Administrators Ltd.** to charge a fee for any pre-authorized payments not honoured by my financial institution.

This agreement will remain in effect until **Canadian Benefit Administrators Ltd.** receives a written notice of cancellation from me, or until I submit a pre-authorized withdrawal form.

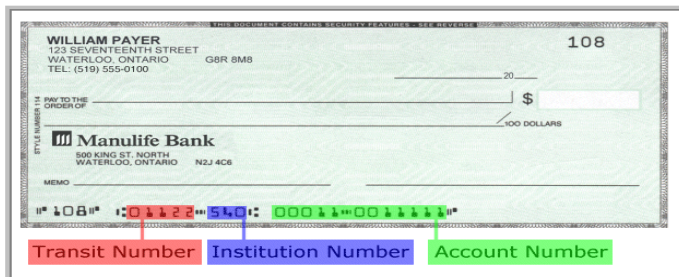
Account Information

Transit number:

Institution number:

Account number:

Where can I find my banking information?



If you are unsure of banking information, please attach a copy of a void cheque.

Signature

Authorized Signature: _____

Date: _____

Print Name: _____

Fax completed form to CBA at (905) 873-1860