THE EXECUTIVE BENEFITS PLAN

BENEFIT SOLUTIONS FOR PROFITABLE ENTREPRENEURS

Administered by

the benefits trust

3800 Steeles Avenue West, Suite 102W
Vaughan, Ontario L4L 4G9
416-498-7723 or 905-264-8990
www.thebenefitstrust.com

THE EXECUTIVE BENEFITS PLAN

The Executive Benefits Plan allows business owners to pay for medical and dental expenses in the most tax effective way possible. This plan enables you to choose where to spend your benefit dollars, without the limitations, maximums, and constraints of many traditional benefits plans. We combine this Executive Benefits plan design with catastrophic event insurance to further protect your executive team against financially devastating medical expenses.

Opportunity

- To pay all medical and dental expenses for you and your family through your business with pre-tax dollars.
- To provide employees with a flexible, tax effective employee benefits plan within your budget.
- Available to all corporations, partnerships, and sole proprietors.

What are Executive Benefits?

- A defined benefit plan, much like a traditional style benefit plan. Unlike a traditional plan, all medical and dental claims are paid at 100% - no deductibles, no coinsurance, no maximums. Items that are not eligible under most plans – such as orthodontics, dental implants, & laser eye surgery – will be reimbursed in full.
- Convenient claims submission: pay-direct drug card, electronic dental, all claims can be submitted by mail, fax, or email.

WE HELP SUCCESSFUL BUSINESS OWNERS BUILD A BETTER BENEFITS PLAN THAN THEY CAN GET ANYWHERE ELSE.

THE EXECUTIVE BENEFITS PLAN

How The Plan Works

- Estimate your family's expected medical and dental expenses for the next year.
    - Include in your estimate: repeat prescription drug expenses, regular dental check-ups, orthodontics or dental implants, eye glasses, contact lenses, or laser eye surgery, chiropractic and massage therapy expenses, and any other expected medical or dental expenses.
- There are no preset maximums. Premiums are based on anticipated expenses and the plan operates on a **budgeted** Administrative Services Only basis. In other words, you will pay the same amount each month. If contributions exceed claims at the end of the year, there is a surplus in your account. If claims exceed contributions at the end of the year, there is a deficit in your account. The surplus or deficit belongs to you and will be reconciled at the end of the benefit year.
- Every month you will receive a financial statement so that you can see how your plan is performing. You will never be surprised at the annual renewal.
- Minimum annual contribution $3,000 for you and your family.
- Deposit the first month's contribution plus the appropriate taxes and administration charges into your specific trust account, which is maintained and administered by The Benefits Trust. A worksheet is included with this package.
- Ongoing monthly contributions will be automatically withdrawn from your bank account. A pre-authorized payment form is included with this application.
- Claims can be submitted at any time and for any amount throughout the benefit year.

Taxation

- 100% of the deposits into the Executive Benefits Plan, including administration and applicable taxes, are tax deductible business expenses.
- All benefits received are non-taxable to the individual.
- Billed taxes (Ontario):

  2.0% premium tax charged on EHC & Dental contributions.
  8.0% provincial insurance tax charged on EHC & Dental contributions and insurance premiums.
  13.0% HST charged on administration fee and premium tax.

Administration Fees

- 15.0% administration fee is automatically built into your EHC & Dental contributions.
- There are no other administration fees.

Please contact our office with any questions about applicable taxes in other provinces.

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Catastrophic Event Insurance Protection and Additional Services

Out of Country Emergency Medical Care

- Insurance coverage for reasonable and customary charges in the area where the emergency occurred, in the event of a sudden, unexpected illness or injury during the first 60 days of travel for business or pleasure. This plan includes hospital care, physician's services, and other appropriate standard medical treatment.
- Maximum $5,000,000 per covered person in their lifetime.
- Supplementary Travel Assist Services are provided for personal or medical emergencies.
- Underwritten by RSA Travel Insurance Inc.
- For employees age 70 and over: Six month Pre-Existing Condition stability clause.

Excess Medical Stop Loss Insurance

- Supplemental Insurance protection for catastrophic in-Canada Health Care claims in excess of $5,000 per person per year. Coverage includes Semi-Private Hospital Room, Private Duty Nursing and Prescription Drugs. This plan also covers each person for recurring treatments.
- A standard 12/24 month pre-existing conditions clause applies to all participants in this plan.
- Maximum $1,000,000 per covered person in their lifetime.
- Underwritten by RSA Travel Insurance Inc.

Monthly Premium for Catastrophic Event Insurance Protection

Includes Out of Country Emergency Medical Care and Excess Medical Stop Loss Insurance:

	Under Age 70	Age 70 to 79
Single:	$21.15 per month	$35.35 per month
Family:	$42.30 per month	$70.70 per month

Prices valid from January 1, 2016 until December 31, 2016.

Eligible Expenses Include:

- **Paramedical Practitioners**
  - such as Acupuncturist, Chiropodist, Podiatrist, Chiropractor, Clinical Counsellor, Dietician, Massage Therapist, Naturopath, Occupational Therapist, Osteopath, Physiotherapist, Psychologist, Social Worker & Speech Therapist
- **Vision Care**
  - including Laser Eye Surgery, Contact Lenses, Glasses & Examinations
- **Medical Facilities**
  - including Hospitals, Convalescent Homes & Substance Abuse Facilities
- **Medical Devices**
  - such as Orthotics, Hearing Aids & CPAP machines
- **Nursing Care**
  - to help you recuperate in the comfort of your own home
- **Expenses Related to Disabilities**
  - including special programs tuition, tutoring and home or vehicle modifications
- **Dental Services**
  - Orthodontic & Major Services including Dental Implants
- **Out of Country Expenses**
  - for non-emergency expenses while travelling
- **Prescription Drugs**
  - excluding only over-the-counter medication

the benefits trust

Application Checklist

Submission Guidelines

Minimum $3,000 in annual EHC & Dental funding for participating member. No minimum funding requirement for employees (if applicable).

Member (and eligible employees if any) must work a minimum of 24 hours per week.

Complete applications received at The Benefits Trust on or before the 10th of the month will take effect the first of the following month.

NOTE: Incomplete applications will not be processed until all materials are received at The Benefits Trust.

The following materials are enclosed (√) with this submission:

❑ Premium Calculation Worksheet and Premium Deposit for $ _____

❑ Enrollment Forms for member & eligible employees. Number enclosed: _____

❑ Master Application, completed and signed by client.

❑ Pre-Authorized Payment Form with Void cheque.

Rather than send in a binder cheque, you may authorize The Benefits Trust to take the deposit via PAP. Advisor or client initial for authorization: _____

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the benefits trust

For internal use only

Contract # _____

Executive Benefits Plan Application

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: _____

For internal use only

Agent Number: _____

Commission Scale: _____

Business Information

Nature of Business: _____

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

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

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

Benefits Insured: _____

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

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.
- The benefit year will be the 12 month period following the effective date.
- Coverage ceases at age 80 or ealier retirement.

Class	Class Description
A	

Extended Health Care

Benefit Year:	12 month period following effective date
Deductible:	Nil

Prescription drugs:	100% (pay-direct prescription drug card)
In province hospitalization:	100% for Private room
Nursing care:	100%
Ambulance, laboratory and out patient:	100%
Paramedical Care:	100%
Appliances:	100%
Orthopaedics:	100%
Physician's Services:	100%
Vision Care:	100%
Hearing aids:	100%
Dental accident:	100%
Travel assistance:	100%
Out of Canada emergency care:	100%

Maximums:	$1,000,000 lifetime benefit per Covered Person for in-Canada Health Care claims. $5,000,000 lifetime benefit per Covered Person Out of Canada emergency care.
Termination Age:	80 or earlier retirement.

Dental Care

Benefit Year:	12 month period following effective date
Deductible:	Nil
Fee Guide:	Submitted fees for General Practitioners and Specialists in the province where treatment is rendered
Part A Services:	100% for Preventative, Diagnostic, Emergency, Palliative, Restorative or Minor Surgical Services, including Denture repair, reline and rebase
Part B Services:	100% for Endodontic or Periodontic Services
Part C Services:	100% for Prosthodontic or Major Restorative Services
Part D Services:	100% for Orthodontic Services including services for adults
Recall Period:	As frequently as recommended by treating dentist.
Maximum:	Unlimited per Covered Person per benefit year.
Termination Age:	80 or earlier retirement.

The Executive Benefit Plan

Enrollment Form

Corporate Information

Company Name

_____

Address: _____

City: _____ Province: _____ Postal Code: _____

Phone: _____ Fax: _____ Email: _____

Personal Information

☐ Mr. ☐ Mrs.

Last Name: _____ First Name: _____ ☐ Ms. ☐ Miss

Address: _____ Apt. # _____

City: _____ Province: _____ Postal Code: _____

Date of Birth: (Month) _____ (Day) _____ (Year) _____ S.I.N. : _____ - _____ - _____

Sex: ☐ M ☐ F Personal Email: _____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Common Law ☐ Length of C/L Relationship: _____

Dependant Information

Please list all dependants including your spouse, common-law spouse (relationship of at least one year), and/or children. Children are eligible if under age 21, or under age 26 and attending school full time, or disabled and completely dependent on you for support. Complete an "**Overage Dependant**" form if applicable.

	Last Name	First Name		Date of Birth (Month)	(Day)	(Year)
Spouse			☐ M ☐ F			
1. Child			☐ M ☐ F			
2. Child			☐ M ☐ F			
3. Child			☐ M ☐ F			
4. Child			☐ M ☐ F			

Member's Authorization

I hereby apply for the benefits for which I am or may become eligible, subject to any waiver indicated, under the Participation Agreement issued by The Benefits Trust and authorize that any required contributions be deducted from my earnings. In addition, I authorize The Benefits Trust and its administrators to use my social insurance number, if applicable, for identification purposes in the administration of the benefits plan. On behalf of myself and my dependents, I also authorize The Benefits Trust (including its affiliates and/or insurance partners) to exchange the information detailed in this Enrollment and any other benefit related information contained in files regarding me or my dependents, now or in the future, for the purposes of administration and/or management of the Participation Agreement issued by The Benefits Trust. I have not received tax advice from The Benefits Trust, it administrators, or any of its agents.

Member's Signature: _____ Date: (Month) _____ (Day) _____ (Year) _____

Claims Direct Deposit Authorization Form
(Electronic Funds Transfer)

You may choose to have claims payments from The Benefits Trust deposited directly to your bank account. Explanations of benefits will be sent by email to the address provided on this form. **Please print clearly.** To set up this convenient process, complete this form and return it with a "void" cheque to The Benefits Trust.

Employee Information

Employee Name (as shown for banking purposes):

_____

Employee Email: _____

Employer Name: _____

Contract or Group No: _____ Certificate No: _____

Attach "void" cheque

I authorize The Benefits Trust to deposit all future claims payments directly to the account shown on the attached "void" cheque. I understand that any change to this authorization must be submitted in writing.

Signature: _____ Date: _____

Return the completed form by mail, email, or fax with a "void" cheque. Please contact our office with questions.

The Benefits Trust
3800 Steeles Avenue West, Suite 102W
Vaughan, Ontario L4L 4G9

Phone: 905-264-8990
Toll Free: 800-487-2993

Fax: 905-264-1123
Email: claims@thebenefitstrust.com

For internal use only

EFT Processed: _____

PAYOR'S AUTHORIZATION FOR PRE-AUTHORIZED DEBITS FOR BUSINESS PURPOSES

1. Payor's Name and Address – please print

   We warrant and represent that the following information is accurate.

Company Name		
Street		
Town	Postal Code	Telephone No.

Name of Payor's Financial Institution (the "Processing Institution")			
Street			Town
Postal Code	Bank No.	Transit No.	Account No.

   We have attached a specimen cheque marked "VOID" to this payor authorization (the "Authorization").

   We will inform the Payee, in writing, of any change in the information provided in this section of the Authorization prior to the next due date of the PAD.

2. Payee's Name and Address – please print

Name of Payee (the "Payee") The Benefits Trust		
Street: 3800 Steeles Avenue West, Suite #102W		
Town: Vaughan, Ontario	Postal Code: L4L 4G9	Tel: (905) 264-8990

3. We acknowledge that the Authorization is provided for the benefit of the Payee and the Processing Institution and is provided in consideration of the Processing Institution agreeing to process debits against our account, as listed above, (the "Account") in accordance with the Rules of the Canadian Payments Association.

4. We warrant and guarantee that all persons whose signatures are required to authorize withdrawals from the Account have signed the Authorization and that all persons signing this Authorization are our authorized signing officers and are empowered to enter into this agreement.

5. We hereby authorize the Payee to issue Pre-Authorized Debits (as defined in Rule H4 of the Rules of the Canadian Payments Association) (the "PAD") drawn on the Account, for the following purpose:
   - payment of group employee benefit plan.

6. We may cancel the Authorization at any time upon providing written notice to the Payee.

7. We acknowledge that provision and delivery of the Authorization to the Payee constitutes delivery by us to the Processing Institution. Any delivery of the Authorization to the Payee, regardless of the method of delivery, constitutes delivery by us.

8. Unless otherwise agreed to in writing, the Payee will provide to us, at the address provided in Section 1:

   a) with respect to fixed amount PADs, written notice of the amount to be debited (the "Payment Amount") and the date(s) on which the Payment Amount debited will be posted to our Account (the "Payment Date"), at least 10 calendar days before the Payment Date of the first PAD, and such notice shall be provided every time there is a change in the Payment Amount or the Payment Date(s);

   b) with respect to variable amount PADs, written notice of the Payment Amount and the Payment Date(s), at least 10 calendar days before the Payment Date of every PAD; and

   c) with respect to a PAD plan that provides for the issuance of a PAD in response to a direct action of ours (such as, but not limited to, a telephone instruction) requesting the Payee to issue a PAD in full or partial payment of a billing received by us for a payment obligation that meets the requirements of Section 2 or Rule H4, no notice is required.

9. The Payee may issue a PAD monthly in a dollar amount as presented to the Payor and may vary with usage and taxes.

10. We acknowledge that the Processing Institution is not required to verify that a PAD has been issued in accordance with the particulars of the Authorization including, but not limited to, the amount, or that any purpose of payment for which the PAD was issued has been fulfilled by the Payee as a condition to honouring a PAD issued by the Payee on the Account.

11. Revocation of the Authorization does not terminate any contract for goods or services that exists between us and the Payee. The Authorization applies only to the method of payment and does not otherwise have any bearing on the contract for goods or services exchanged.

12. We may dispute a PAD only under the following conditions:
    (i) the PAD was not drawn in accordance with the Authorization;
    (ii) the Authorization was revoked; or
    (iii) pre-notification, as required under Section 8 was not received.

    We acknowledge that in order to be reimbursed a declaration to the effect that either (i), (ii) or (iii) took place, must be completed and presented to the branch of the Processing Institution holding the Account up to and including 10 business days after the date on which the PAD in dispute was posted to the Account.

    We acknowledge that when disputing any PAD beyond the time allowed in this section, it is a matter to be resolved solely between us and the Payee, outside the payment system.

13. We agree that the information contained in the Authorization may be disclosed to the Payee's Financial Institution as required to complete any PAD transaction.

14. We understand and accept the terms of participating in this PAD plan.

_____
(COMPANY NAME)

_____
(AUTHORIZED SIGNATURE)

_____
(AUTHORIZED SIGNATURE)