the benefits trust
Since 1994

For internal use only

Contract # _____

Group Benefits Master Application

Applicant Information

Effective Date Requested

Legal Company Name: _____ (Month) _____ (Day) 01 (Year) _____

Operating as (if different): _____ Benefit Year _____
(if different from effective year)

Address: _____

City: _____ Province: _____ Postal Code: _____

Administrator Name: _____ Title: _____

Phone: _____ Fax: _____ Email: _____

Executive Contact (if different): _____ 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)

_____ ☐ Take via Pre-Authorized Payment (PAP)
(Applicant's printed name) (Please complete the enclosed PAP form)

Broker / Agent Information and Declaration

Send New Plan ID Cards to: ☐ Client ☐ Broker

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: _____

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

Benefits Insured: _____

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

Benefits Insured: _____

Summary Employee Information

Number of Eligible Employees:_____ Regular Number of Hours Worked (for example 37.5 hrs or 40 hrs/week): _____

Minimum Number of Hours Worked for Eligibility (for example 30 hrs/week): _____

Waiting period for Full Time Employees: ☐ _____ Months ☐ First of Next Month ☐ Other: _____

Waiting period for Other Employees (if different): ☐ _____ Months ☐ First of Next Month ☐ Other: _____

Is Coverage required for:

Retirees?	☐ Yes	☐ No	Contract Employees?	☐ Yes	☐ No
Seasonal Employees?	☐ Yes	☐ No	Commissioned Employees?	☐ Yes	☐ No

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:

_____

_____

_____

_____

_____

_____

_____

_____

_____

Billing and Benefit Information

Use Billing Divisions? ☐ Yes ☐ No If Yes, attach list. Enrollment forms should indicate Dept. for each employee
(for example: Western Canada, Eastern Canada, Central)

Use Departments? ☐ Yes ☐ No If Yes, attach list. Enrollment forms should indicate Division for each employee
(for example: Sales, Manufacturing, Finance)

Fully Insured Benefit Options (please check all that apply):

☐ Basic Life ☐ Optional Life ☐ Dependent Life

☐ A.D. & D. ☐ Optional A.D. & D.

☐ Long Term Disability ☐ Critical Illness

☐ Excess Medical Stop Loss (choose one) ☐ $7,500 ☐ $10,000 ☐ $12,500 ☐ $15,000

☐ Out of Country Emergency Medical with Travel Assist

Services Options (please check all that apply):

☐ Employee Assistance Program (EAP) ☐ Wellness Program ☐ Akira ☐ Best Doctors

☐ ConnectsUs HR Resource Kit (free) ☐ Rupert Case Management

Self Funded Benefit Options (please check all that apply):

☐ Extended Health Care ☐ Dental Care ☐ Health Care Spending Account

☐ Short Term Disability ☐ Survivor Benefits

Contributions

The **Employer** will be paying the following percentage of contributions:

Note: If Long Term Disability benefit or Short Term Disability benefit is to be non-taxable, the **Employee** must contribute 100% of the cost for that benefit.

Schedule of Benefits

Class **Class Description**

A _____

Life Insurance ☐ Yes ☐ No

Type: ☐ Flat Amount _____ ☐ Multiple of Earnings _____

Overall Maximum: _____ Non-Evidence Maximum: _____

Reduction: _____ % at age _____ , and further reducing to _____ % at age _____

Termination Age: _____ Employee Optional Life: ☐ Yes ☐ No Spousal Optional Life: ☐ Yes ☐ No

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Accidental Death & Dismemberment ☐ Yes ☐ No Coverage to match Life Insurance? ☐ Yes ☐ No (complete section)

Type: ☐ Flat Amount _____ or ☐ Multiple of Earnings _____

Overall Maximum: _____ Non-Evidence Maximum: _____

Reduction: _____ % at age _____ , and further reducing to _____ % at age _____

Termination Age: _____ Employee Optional AD&D: ☐ Yes ☐ No Spousal Optional AD&D: ☐ Yes ☐ No

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Dependent Life Insurance ☐ Yes ☐ No

Spouse: _____ Each Child: _____ Child covered from age: _____

Long Term Disability ☐ Yes ☐ No

Benefit Formula: _____ % of the first _____ of monthly earnings

plus _____ % of the next _____

plus _____ % of the balance

Overall Maximum: _____ Non-Evidence Maximum: _____

Disability Definition: _____

Elimination Period: _____ Benefits Payable To: _____

CPP/QPP Offsets: _____ Pre-Existing Condition: _____

Earnings Definition: _____ COLA: _____ %

Termination Age: _____ ☐ Taxable (premium paid by employer) ☐ Non-Taxable (premium paid by employee)

Critical Illness ☐ Yes ☐ No

Amount: _____

Termination Age: _____

Class	Class Description
A	

Short Term Disability ☐ Yes ☐ No

Benefit Formula: ☐ _____ % of weekly earnings or ☐ Flat Amount _____

Benefit Maximum: ☐ _____ per week or ☐ Match EI Maximum

Commencement of Coverage for: Accident: _____ Sickness: _____ Hospital: _____

Maximum Benefit Period: _____ E.I. Offset: _____

Termination Age: _____ ☐ Taxable (premium paid by employer) ☐ Non-Taxable (premium paid by employee)

Extended Health Care ☐ Yes ☐ No ☐ Match prior carrier coverage (must provide booklet) ☐ Executive 100% Coverage
To make any changes to your coverage, indicate below — If you checked, skip this section

Deductible: _____ per person to a maximum of _____ per Family per Benefit Year

Deductible Not Applicable To: _____

☐ Prescription Drugs: _____ % Drug Max: _____ ☐ Generic Substitution ☐ Mandatory Generic

Per Prescription Deductible: _____ Dispensing Fee Max: _____

Drug Inclusions: _____

Drug Exclusions: _____

☐ Hospital _____ % ☐ Semi-Private ☐ Private ☐ Convalescent Home

☐ Private Duty Nursing _____ % Maximum per Benefit Year _____ per Covered Person

☐ Ambulance & Lab _____ %

☐ Paramedical _____ % Maximum per Benefit Year _____ per Discipline per Covered Person

If any Discipline differs from the above, provide details: _____

☐ Medical Appliances _____ % (If applicable) Maximum for all medical appliances combined per Year _____

☐ Orthopaedics _____ % Maximum per Benefit Year for shoes / inserts combined _____ per Covered Person

☐ Surgical Stockings _____ % Maximum per Benefit Year _____ per Covered Person

☐ Vision Care _____ % Maximum per ☐ 12 ☐ 24 Months for glasses and/or contacts _____ per Covered Person

Include corrective laser eye surgery as eligible vision care expense? ☐ Yes ☐ No

☐ Eye Examinations _____ % Maximum per ☐ 12 ☐ 24 Months for eye examinations _____

☐ Hearing Aids _____ % Maximum _____ per Person per _____ consecutive months

☐ Accidental Dental maximum $3,000 per Covered Person in their lifetime

☐ Out of Country Emergency Medical with Travel Assist

☐ Excess Medical Stop Loss Insurance

Termination Age: _____ ☐ Survivor Benefits (24 months)

Class **Class Description**

A _____

Dental Care ☐ Yes ☐ No ☐ Match prior carrier coverage (must provide booklet) ☐ Executive 100% Coverage

To make any changes to your coverage, indicate below

If you checked, skip this section

Deductible: _____ per person to a maximum of _____ per Family per Benefit Year

☐ Level I Basic & Preventive Services:

Co-insurance: _____% Maximum: _____ combined with _____

☐ Level II Endodontics & Periodontics:

Co-insurance: _____% Maximum: _____ combined with _____

☐ Level III Major Restorative Services:

Co-insurance: _____% Maximum: _____ combined with _____

☐ Level IV Orthodontic Services:

Co-insurance: _____% Maximum: _____ combined with _____

Includes Orthodontic Services for Adults? ☐ Yes ☐ No

Dental Fee Guide: _____ Recall: _____ Scaling Units: _____

Termination Age: _____ ☐ Survivor Benefits (24 months)

Health Care Spending Account ☐ Yes ☐ No

Choose Funding Type Below:

☐ Flat Benefit Amount: _____ per Benefit Year

☐ Percentage of Earnings: _____

☐ Years of Service: _____ per year to a maximum of _____

If your desired plan design does not fit these templates, please use the Notes section.

Carry Forward Type: ☐ Balance Carry Forward (standard) ☐ Expense Carry Forward ☐ No Carry Forward

Termination Age: _____ ☐ Survivor Benefits (24 months)

Notes:

Schedule of Benefits

Class **Class Description**

B _____

Life Insurance ☐ Yes ☐ No

Type: ☐ Flat Amount _____ ☐ Multiple of Earnings _____

Overall Maximum: _____ Non-Evidence Maximum: _____

Reduction: _____ % at age _____ , and further reducing to _____ % at age _____

Termination Age: _____ Employee Optional Life: ☐ Yes ☐ No Spousal Optional Life: ☐ Yes ☐ No

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Accidental Death & Dismemberment ☐ Yes ☐ No Coverage to match Life Insurance? ☐ Yes ☐ No (complete section)

Type: ☐ Flat Amount _____ or ☐ Multiple of Earnings _____

Overall Maximum: _____ Non-Evidence Maximum: _____

Reduction: _____ % at age _____ , and further reducing to _____ % at age _____

Termination Age: _____ Employee Optional AD&D: ☐ Yes ☐ No Spousal Optional AD&D: ☐ Yes ☐ No

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Dependent Life Insurance ☐ Yes ☐ No

Spouse: _____ Each Child: _____ Child covered from age: _____

Long Term Disability ☐ Yes ☐ No

Benefit Formula: _____ % of the first _____ of monthly earnings

plus _____ % of the next _____

plus _____ % of the balance

Overall Maximum: _____ Non-Evidence Maximum: _____

Disability Definition: _____

Elimination Period: _____ Benefits Payable To: _____

CPP/QPP Offsets: _____ Pre-Existing Condition: _____

Earnings Definition: _____ COLA: _____ %

Termination Age: _____ ☐ Taxable (premium paid by employer) ☐ Non-Taxable (premium paid by employee)

Critical Illness ☐ Yes ☐ No

Amount: _____

Termination Age: _____

Class	Class Description
B	

Short Term Disability ☐ Yes ☐ No

Benefit Formula: ☐ _____ % of weekly earnings or ☐ Flat Amount _____

Benefit Maximum: ☐ _____ per week or ☐ Match EI Maximum

Commencement of Coverage for: Accident: _____ Sickness: _____ Hospital: _____

Maximum Benefit Period: _____ E.I. Offset: _____

Termination Age: _____ ☐ Taxable (premium paid by employer) ☐ Non-Taxable (premium paid by employee)

Extended Health Care ☐ Yes ☐ No ☐ Match prior carrier coverage (must provide booklet) ☐ Executive 100% Coverage

To make any changes to your coverage, indicate below

If you checked, skip this section

Deductible: _____ per person to a maximum of _____ per Family per Benefit Year

Deductible Not Applicable To: _____

☐ Prescription Drugs: _____ % Drug Max: _____ ☐ Generic Substitution ☐ Mandatory Generic

Per Prescription Deductible: _____ Dispensing Fee Max: _____

Drug Inclusions: _____

Drug Exclusions: _____

☐ Hospital _____ % ☐ Semi-Private ☐ Private ☐ Convalescent Home

☐ Private Duty Nursing _____ % Maximum per Benefit Year _____ per Covered Person

☐ Ambulance & Lab _____ %

☐ Paramedical _____ % Maximum per Benefit Year _____ per Discipline per Covered Person

If any Discipline differs from the above, provide details: _____

☐ Medical Appliances _____ % (If applicable) Maximum for all medical appliances combined per Year _____

☐ Orthopaedics _____ % Maximum per Benefit Year for shoes / inserts combined _____ per Covered Person

☐ Surgical Stockings _____ % Maximum per Benefit Year _____ per Covered Person

☐ Vision Care _____ % Maximum per ☐12 ☐24 Months for glasses and/or contacts _____ per Covered Person

Include corrective laser eye surgery as eligible vision care expense? ☐ Yes ☐ No

☐ Eye Examinations _____ % Maximum per ☐12 ☐24 Months for eye examinations _____

☐ Hearing Aids _____ % Maximum _____ per Person per _____ consecutive months

☐ Accidental Dental maximum $3,000 per Covered Person in their lifetime

☐ Out of Country Emergency Medical with Travel Assist

☐ Excess Medical Stop Loss Insurance

Termination Age: _____ ☐ Survivor Benefits (24 months)

Class	Class Description
B	

Dental Care ☐ Yes ☐ No ☐ Match prior carrier coverage (must provide booklet) ☐ Executive 100% Coverage

To make any changes to your coverage, indicate below

If you checked, skip this section

Deductible: _____ per person to a maximum of _____ per Family per Benefit Year

Deductible Not Applicable To: _____

☐ Level I Basic & Preventive Services:

Co-insurance: _____% Maximum: _____ combined with _____

☐ Level II Endodontics & Periodontics:

Co-insurance: _____% Maximum: _____ combined with _____

☐ Level III Major Restorative Services:

Co-insurance: _____% Maximum: _____ combined with _____

☐ Level IV Orthodontic Services:

Co-insurance: _____% Maximum: _____ combined with _____

Includes Orthodontic Services for Adults? ☐ Yes ☐ No

Dental Fee Guide: _____ Recall: _____ Scaling Units: _____

Termination Age: _____ ☐ Survivor Benefits (24 months)

Health Care Spending Account ☐ Yes ☐ No

Choose Funding Type Below:

☐ Flat Benefit Amount: _____ per Benefit Year

☐ Percentage of Earnings: _____

☐ Years of Service: _____ per year to a maximum of _____

If your desired plan design does not fit these templates, please use the Notes section.

Carry Forward Type: ☐ Balance Carry Forward (standard) ☐ Expense Carry Forward ☐ No Carry Forward

Termination Age: _____ ☐ Survivor Benefits (24 months)

Notes: