ABC BENEFITS

APPLICATION FOR GROUP INSURANCE

For Office Use Only

Policy No._____

PLEASE NOTE: ALL QUESTIONS MUST BE ANSWERED IN FULL TO PROCESS THIS APPLICATION.

POLICYHOLDER DETAILS

Full Legal Name: _____ Contact Name: _____

Full Address: _____ Phone Number: _____

_____ Fax: _____

_____ Email: _____

Nature of Business: _____

Legal Status: ☐ Corporation (or) ☐ Sole Proprietor (or) ☐ Partnership (or) ☐ Other
Indicate name of Sole Proprietor or names of all legal parties and % of ownership below:

_____

CURRENT COVERAGE

Will the insurance applied for replace similar insurance? ☐ No ☐ Yes If "yes", please complete the following:

TO AVOID A PERIOD WITHOUT COVERAGE, DO NOT TERMINATE ANY EXISTING COVERAGE UNTIL APPROVAL IS CONFIRMED IN WRITING.

Name of current carrier: _____ Issue Date: _____

Date present coverage to be terminated: _____

Current Benefits: ☐ Life /A.D.&D. ☐ Dependent Life ☐ Weekly Indemnity ☐ Long Term Disability
☐ Extended Health ☐ Dental Survivor Benefits: ☐ Health ☐ Dental

PREVIOUS COVERAGE

If you have had any group insurance coverage in the last 5 years, prior to your current coverage, please specify below:

Name of Carrier	Effective Date	Termination Date
_____	_____	_____
_____	_____	_____

The requested effective date for all coverage is 12:01a.m., STANDARD TIME, on the first day of _____ , _____
month year

Waiting Period: all employees who are active, full time and working on a permanent basis (at least 25 hours per week) to be covered on the effective date. New permanent employees, employed after the effective date and working a minimum of 25 hours per week, are eligible after three months of continuous full-time employment.

Eligible Employees: All employees working at least 25 hours per week.
_____ # of eligible full-time employees _____ # of employees to be insured on effective date _____ # of part-time employees

Do all employees receive T4's? ☐ Yes ☐ No

Employer Contribution To Premiums: ☐ 100% to ALL benefits, (or) ☐ as follows:

_____ % : Life _____ % : Extended Health Care _____% : Dental Care

_____ % : Dependent Life _____ % : Optional Life _____% : W.I. _____% : Long Term Disability

DESCRIPTION OF BENEFITS APPLIED FOR

☑ **Basic Life (Mandatory)**

All Employees: Flat amount: $ 20,000

REDUCTION PROVISION: Amounts of Life Insurance reduce 50% on the employee's 65th birthday and terminate upon attainment of the employee's age of 75 assuming they are working at least 25 hours per week.

Please note: One (1) Health & One (1) Dental Care Option must be chosen.

☐ **Extended Health Care** Please indicate ☑ the plan coverage you desire. Choose one (1) of these three (3) options:

- ☐ **Plan A:** 80% co-insurance for *Drugs (Rx) with 100% co-insurance for all else with nil deductible overall.
- ☐ **Plan B:** 100% co-insurance with a dispensing fee deductible applicable to *Drugs (Rx).
- ☐ **Plan C:** 100% co-insurance with nil deductible.

☐ **Vision Care *(optional)*:** 100% co-insurance with nil deductible / $150 every 24 consecutive months.

* Drug plans include a Pay Direct Reimbursement Card.

☐ **Dental Care** Please indicate ☑ the plan coverage you desire. Choose one (1) of these two (2) options:

- ☐ **Plan 1:** 80% co-insurance with a maximum of $1,500 per person per calendar year.
- ☐ **Plan 2:** 100% co-insurance with a maximum of $1,500 per person per calendar year.

☐ **Weekly Indemnity** ☐ **Long Term Disability** ***(if quoted and accepted, please complete Form 2)***

COVERAGE FOR DEPENDENT CHILDREN

Eligible dependent children are covered to age 21. Dependent children in full-time attendance at school are covered for Extended Health and Dental Expense Benefits to age 25.

TERMINATION OF BENEFITS

All benefits terminate at the Insured Employee's Age 75 or prior retirement.

REQUEST FOR AUTOMATIC BANK WITHDRAWALS OR MONTHLY INVOICING
(Check One)

☐ Automatic Bank Withdrawals: Macdonald Administration Services Limited is hereby authorized to perform a withdrawal each month for the purpose of paying premiums for the policy referred to herein. The policyholder hereby authorizes any banking institution with whom it has an account to deal with such cheques or directions as though they were authorized by itself. The estimated first month's premium and a void cheque are attached to this Application.

☐ Monthly Invoicing: Macdonald Administration Services Limited will distribute a monthly invoice to the Contact Name prior to the month the premium is due with a standard Period of Grace of not more than 31 days.

APPLICATION TO PARTICIPATE IN THE ABC BENEFITS PROGRAM

The Applicant desires to become a participating employer under the **ABC BENEFITS PROGRAM** and obtain Insurance benefits for eligible employees under the policies issued to the Program by Desjardins Financial Security.

THE APPLICANT DECLARES:

The Applicant declares that, to the best of the Applicant's knowledge, the statements and answers contained on this application are full, complete and true as of the date hereof and agrees that the insurance shall become effective in accordance with the Application but in no event shall it become effective until this Application has been approved by Macdonald Administration Services Limited and the necessary premium payment is received on account. Submission of a valid cheque will not in itself constitute approval of the application.

In case of apparent errors or omissions discovered by Macdonald Administration Services Limited, they are hereby authorized to amend this Application by noting the change(s). A copy of this Application, so amended, will be sent to the Applicant to constitute acceptance.

An initial Premium Deposit of $ _____ (as per cost proposed summary) is included with the Application. The Applicant agrees to notify Macdonald Administration Services Limited in writing of an employee who becomes disabled between the date of this Application and the effective date of the Policy.

Applicant: _____ Authorized Signature & Title: _____

Witness: _____ Dated at: _____

SALES AGENT NAME : M. Dracup and G. Georgiopoulos **MGA NAME :** Dundee