Group Insurance Application

Section 1 Client Information

Please print clearly

Legal Company Name

Name of Plan Administrator | Title

Address

Telephone | Fax

Email Address

Effective Date of Coverage (yyyy/mm/dd)

Section 2 General Business Information

Business Description | Number of Years in Business (minimum one year)

Eligible Employees ❑ All Employees ❑ Management ❑ Other

Classes ❑ Yes (if yes, please define) ❑ Class A
❑ No ❑ Class B

Waiting Period for New Employees: ❑ 3 Month ❑ Other
❑ 6 Month Unless otherwise indicated, 1st month coincident with or next following 3 months of employment

Number of Full-time Employees | Number of Eligible Employees

Are all employees actively at work? ❑ Yes
❑ No (if no, please complete information below)

Employee Name	Reason for Absence	Last Day Worked	Expected Return Date

Name of Current Insurer (if applicable) | Please attach a copy of the most recent billing statement

Section 3 Benefit Information

Check appropriate boxes to indicate your benefit selections. In addition to Basic Life, Accidental Death & Dismemberment, and Dependent Life, you must select at least two of: Weekly Indemnity, Long Term Disability, Extended Health Care and Dental Care. Critical Illness is not part of the core package requirements. Please ensure that all your benefit selections are clearly marked.

☑ Life and Accidental Death & Dismemberment Benefits (Mandatory)

Benefit Options

❑ flat $25,000
❑ flat $50,000
❑ flat $75,000
❑ flat $100,000

❑ 1x annual earnings
❑ 2x annual earnings
❑ 3x annual earnings

Benefit Maximum

$________________________
Select maximum up to $500,000
not required for flat benefit option

❑ Other

☑ Dependent Life Benefit (Mandatory)

Please print clearly

Benefit Options

❑ $5,000 spouse, $2,500 each dependent child
❑ $10,000 spouse, $5,000 each dependent child
❑ $25,000 spouse, $12,500 each dependent child

❑ Other

❑ Weekly Indemnity

Benefit Options

❑ 60% of salary
❑ 66 2/3% of salary

Benefit Duration

❑ 17 weeks
❑ 26 weeks
❑ 52 weeks

Benefit Maximum

$ ______________________
Select maximum up to $1,000

❑ Other

❑ Long Term Disability

Benefit Options

❑ 60% of salary
❑ 66 2/3% of salary
❑ 66 2/3% of first $2,500, 45% thereafter

Elimination Period

❑ 17 weeks
❑ 26 weeks
❑ 52 weeks

Benefit Maximum

$ ______________________
Select maximum up to $7,500

COLA Options

❑ not included
❑ 1% ❑ 2% ❑ 3% ❑ 4% ❑ 5%

❑ Other

❑ Critical Illness

Benefit Options

❑ Flat $10,000
❑ Flat $25,000

❑ Other

Non-Evidence Maximums

By Group Size

Lives	❑ 3–4	❑ 5–9	❑ 10–14	❑ 15–19	❑ 20–24	❑ 25–34	❑ 35–50
Life NEM	$25,000	$75,000	$150,000	$175,000	$200,000	$250,000	$300,000
LTD NEM	$1,000	$2,000	$2,500	$3,000	$3,500	$4,500	$5,000
CI NEM	$25,000	$25,000	$50,000	$50,000	$50,000	$100,000	$100,000

All coverage for 1 – 2 life groups must be medically underwritten and approved prior to coverage going into effect.

❑ Extended Health Care

Coinsurance

❑ 80% drugs, 80% other
❑ 80% drugs, 100% other
❑ 100% drugs, 100% other

❑ pay direct drug plan
❑ reimbursement drug plan

Deductible

❑ nil
❑ $25 single, $50 family/year
❑ $7 dispensing fee maximum

Paramedical Practitioners

❑ $300/practitioner
❑ $500/practitioner

Vision Care*

❑ not included
❑ $150/24 months
❑ $200/24 months
❑ $250/24 months

*not available to 1-2 life groups

❑ Other

❑ Dental Care

Please print clearly

Basic Services must be included in order to select the Major Services option. Basic Services and Major Services must be selected in order to select Orthodontia.

Basic Services	Major Services	Orthodontia*	Deductible
❑ 80% reimbursement ❑ 100% reimbursement	❑ 50% reimbursement	❑ 50% reimbursement *not available to 1-2 life groups	❑ nil ❑ $25 single, $50 family/year
Benefit Maximum	**Benefit Maximum**	**Benefit Maximum**	**Annual Recall Options**
❑ $1,000/year ❑ $1,500/year	❑ $1,000/year ❑ $1,500/year combined with Basic Services ❑ $2,000/year combined with Basic Services	❑ $1,000 lifetime ❑ $1,500 lifetime ❑ $2,000 lifetime	❑ 6 months ❑ 9 months ❑ 12 months

❑ Other

☑ Optional Benefits

Optional Life		Optional Accidental Death & Dismemberment	
Benefit Options	**Benefit Maximum**	**Benefit Options**	**Benefit Maximum**
☑ employee ☑ spouse ☑ units of $10,000	$250,000	☑ employee only ☑ employee and family ☑ units of $25,000	$250,000

Section 4 Employee Contributions

❑ _________ % of premium

❑ _________ % of premium, where employee's portion covers 100% of Life, Dependent Life, Weekly Indemnity and Long Term Disability

Benefit	Employee Contribution	Benefit	Employee Contribution
❑ Life	_________ %	❑ Long Term Disability	_________ %
❑ AD&D	_________ %	❑ Critical Illness	_________ %
❑ Dependent Life	_________ %	❑ Extended Health Care	_________ %
❑ Weekly Indemnity	_________ %	❑ Dental Care	_________ %

Section 5 Taxability Statement (Complete if Weekly Indemnity and/or Long Term Disability benefits are selected.)

Weekly Indemnity and Long Term Disability benefits received by an employee under a plan where there is an employer contribution are taxable under both the Federal and Quebec Income Tax Acts. In order for the benefit to be non-taxable, the employee must pay the entire cost of the benefit.

All benefit payments under Weekly Indemnity and/or Long Term Disability are as follows:

Weekly Indemnity	❑ Taxable	❑ Non-Taxable
Long Term Disability	❑ Taxable	❑ Non-Taxable

Please note that ENCON must be advised of any future changes in the taxable status of your policy and that unless ENCON receives written advice of the change, taxable status will continue as indicated.

Section 6 Authorization for Automatic Bank Debit

Please print clearly

You may elect to have your monthly premium payments automatically withdrawn from your account. Payments will not commence until the approval of group coverage and until the first of the month following receipt of the completed authorization form. Withdrawals from your account will occur on the first banking day of each month. In advance of the first actual withdrawal, you will receive a statement detailing individual benefit premiums, taxes and totals by insured person.

The undersigned authorizes the financial institution to honour all debits issued by ENCON against this account.

Name of Depositor(s)

Please sign here

Signature of Depositor(s) (if different from signatory below) Date (yyyy/mm/dd)

Please attach here

A sample VOID cheque must be attached in order to process your request

Section 7 Conditions of Agreement

IT IS AGREED THAT

a) The effective date of your group will be the first day of the month following receipt of all required approvals and documentation by ENCON Group Inc.
b) The conditions of eligibility for insurance, the conditions under which insurance will be payable and other contractual terms shall be in accordance with the Master Policy.
c) The program participation requirements will be met: specifically, all eligible employees must participate in Life, Dependent Life and AD&D benefits. For groups with 1 – 9 employees, 100% participation is required. For groups with 10+ employees, 100% participation is required if the employer is paying 100% of the premium and 75% participation is required if the employee pays any portion of the premium.
d) Your group benefits program renews on the first of the month following the first 15 months of coverage and every 12 months thereafter.
e) You will continue to pay ENCON Group Inc. the required premiums to ensure coverage remains in force. Premium payment is due on the first day of the month for that month of coverage.
f) In the event of an unsuccessful withdrawal from your bank account or a returned cheque, a $25 charge will apply.
g) ENCON Group Inc. requires 30 days advance written notice of termination.

Please attached a deposit premium cheque for the first month's estimated monthly premiums, which totals: $____________

Until further notice, the Agent of Record appointed to act on your behalf with respect to the group plan for which this application is made and receive any compensation associated with this plan, is:

Name of Agent

Address

Telephone Fax Email Address

By signing this application, you hereby certify that you have reviewed this application for group insurance benefits, that the information you have provided is true, complete and accurate, that you authorize automatic bank debits as defined in Section 6 and that you have read and understand the Conditions of Agreement in this Section.

Please sign here

Employer Signature Date (yyyy/mm/dd)

Agent Signature Date (yyyy/mm/dd)

Section 8 For Office Use Only

Client Number Health Class Code(s) Dental Class Code(s) Effective Date

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Enrollment/Change Form

Section 1 Employee Information

Please print clearly

Name of Employer			Client No.
Employer's Address			Class/Sort Group
Name of Employee			S.I.N. / Certificate No.
Employee's Address			
Date of Birth (yyyy/mm/dd)	❏ Male ❏ Female	Coverage Option ❏ Single ❏ Family	Occupation
Date of Employment (yyyy/mm/dd)	❏ Full Time ❏ Part Time	Annual Earnings	Number of Hours Worked per Week

Section 2 Dependent Information

Name of Spouse (If common law, please provide date cohabitation commenced.)	❏ Male ❏ Female	Date of Birth (yyyy/mm/dd)	Relationship
Request to Coordinate or Waive Benefits — Coordinate ❏ Health ❏ Dental Waive ❏ Health ❏ Dental	Name of Spouse's Insurance Provider		Policy No.
Name of Dependent	❏ Male ❏ Female	Date of Birth (yyyy/mm/dd)	Relationship
Name of Dependent	❏ Male ❏ Female	Date of Birth (yyyy/mm/dd)	Relationship

Section 3 Change Request

Nature of Change	❏ Termination ❏ Layoff	❏ Reinstatement ❏ Beneficiary	❏ Salary: $ ❏ Dependent Status*	❏ Other:	Effective Date
*Dependent Status Change	❏ Single ❏ Family	❏ Marriage ❏ Birth	❏ Common Law Status (please provide date cohabitation commenced) ❏ Other:		

Section 4 Beneficiary Designation

1. Unless otherwise stipulated and unless prohibited by law, the designation of any beneficiary is revocable.
2. This designation, as authorized by the employee signature and the date below, supercedes any prior beneficiary designation.
3. If any named beneficiary is a minor (under the age of majority) you may want to name a trustee to receive the proceeds in trust for the minor until he/she attains the age of majority. Any appointed trustee will remain valid once the beneficiary reaches the age of majority unless a trustee expiration date is provided below.
4. If more than one beneficiary is designated, in the absence of an employee assigned percentage, the benefit will be split equally among each named beneficiary.

Beneficiary's Full Name	Relationship	Percentage of Benefit Assigned	Trustee Assigned ❏ Yes ❏ No
Beneficiary's Full Name	Relationship	Percentage of Benefit Assigned	Trustee Assigned ❏ Yes ❏ No
Trustee Assignment (recommended if beneficiary is under the age of majority)			Expiry Date of Trustee Appointment

Section 5 Authorization

I hereby apply to enroll in the group benefits program for which I am, or may become, eligible and I agree to be bound by these terms and conditions. I understand that my claims may be denied and/or benefits terminated if I provide false, incomplete or misleading information. I understand that on the date my insurance becomes effective that I must be actively at work.

I authorize ENCON and its insurers to collect, use, disclose, maintain and exchange my information with the understanding that my information will be used solely for the purposes of administration, management of my group benefits plan and adjudication of claims. Access to my information shall be limited to ENCON, its insurers, service providers or persons authorized access by law. This consent shall continue so long as myself and my dependents are covered by, or are claiming benefits under the present group contract or any modification, renewal or reinstatement thereof. I authorize the use of my Social Insurance Number as my employee number for the purpose of identification under this group policy. I acknowledge that specific details of ENCON's Privacy Policy can be found at www.encon.ca

Please sign here

Signature | Date (yyyy/mm/dd)

Employer

The undersigned, on behalf of the above-noted company, hereby certifies that, to the extent that available records and information permit, the statements on this form are true and complete and no material information has been omitted or withheld.

Please sign here

Signature | Date (yyyy/mm/dd)

Evidence of Insurability Form

Section 1 Employee Information

Please print clearly

Name of Employer	Client No.
Employer's Address	
Name of Employee	Occupation
Employee's Address	
Home Telephone	Work Telephone

❑ Male ❑ Female	Date of Birth (yyyy/mm/dd)	Place of Birth (City and Country)	Height (ft./in.)	Weight (lbs.)

Regular Physician or Family Doctor Name and Address

Date and Reason Doctor Last Seen

Section 2 Applicant Questions

Please complete all questions and provide full details of any "Yes" answers in Section 3. If you require additional space, please attach a separate sheet (signed and dated) to avoid unnecessary delays in processing this application.

	Yes	No
1. Have you had any indication of or been treated for:		
a. any disease or disorder of the eyes, ears, nose, mouth or throat, or any allergies including any job-site environmental sensitivity?	❑	❑
b. lung trouble, pneumonia, bronchitis, pleurisy, asthma, emphysema, tuberculosis or any other respiratory disorder?	❑	❑
c. dizziness, fainting, convulsions, headaches, migraines, paralysis or stroke, epilepsy, multiple sclerosis, chronic anxiety, burnout, fatigue, depression or eating disorder?	❑	❑
d. chest pains, palpitations, high blood pressure, phlebitis, rheumatic fever, heart murmur, heart attack or other disorder of the heart or blood vessels?	❑	❑
e. hepatitis, ulcer, hernia, appendicitis, colitis, Crohn's, diverticulitis, hemorrhoids, recurrent indigestion or other disorders of the stomach, intestine, liver or gall bladder?	❑	❑
f. sugar, albumin, protein, blood and/or pus in the urine, sexually transmitted disease, stone or other disorder of kidney, bladder, prostate or reproductive organs?	❑	❑
g. any hereditary disorders or diabetes, thyroid or other endocrine disorders?	❑	❑
h. gout, neuritis, sciatica, rheumatism, arthritis, fibromyalgia, disorder of the muscles or bones, including the spine, back or joints?	❑	❑
i. disorder of the skin, breasts, lymph glands, cysts, tumor or cancer?	❑	❑
j. anemia or other disorder of the blood, or have you ever received a blood transfusion or blood products?	❑	❑
2. Are you currently taking any medication, receiving treatment(s) or following a special diet?	❑	❑
3. Have you ever used or dealt in barbiturates, narcotics, or other drugs or hallucinogens, including marijuana and cocaine, except as prescribed by a physician, or received, been advised to receive or are you currently receiving treatment or counseling for the use of drugs?	❑	❑
4. Have you used any form of tobacco or cannabis in the last 12 months?	❑	❑
5. Do you consume alcoholic beverages? If yes, quantity per week: bottles of beer glasses of wine ounces of liquor	❑	❑
6. Have you ever been advised to drink less alcohol, received treatment or joined an organization because of alcohol? If yes, please provide details:	❑	❑

Continued on the back

Section 2 Applicant Questions (continued)

Please print clearly

Please complete all questions and provide full details of any "Yes" answers in Section 3. If you require additional space, please attach a separate sheet (signed and dated) to avoid unnecessary delays in processing this application.

Question	Yes	No
7. Have you had any driving infractions within the last five years?	❑	❑
8. Have you ever tested positive for, been diagnosed with or been told you have Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) disease?	❑	❑
9. Do you participate in organized contact sports or hazardous activities (e.g., mountain climbing, hang-gliding, scuba-diving, parachuting, flying (pilot/crew member), motorized racing)?	❑	❑
10. Do you contemplate a trip or taking up residence outside Canada or the USA? (Specify location and duration below)	❑	❑
11. Has any application for insurance been rated for higher premium, modified, postponed, declined or rescinded?	❑	❑
12. Are you currently unable to work, whether inside or outside the home? How many work days have you lost due to disability/illness in the last two years?	❑	❑
13. Other than above, have you within the last five years:		
a. been advised to have any diagnostic test, hospitalization or surgery which was not completed?	❑	❑
b. received medical or surgical attention due to illness or injury?	❑	❑
c. been a patient in a hospital, clinic, sanitarium or other medical facility?	❑	❑
d. had an electrocardiogram, x-ray or other diagnostic tests with abnormal findings or indicating any health problems?	❑	❑
e. sought any alternative medical treatment, such as Naturopathy, Acupuncture, Chiropractic care, etc.?	❑	❑
f. requested or received a pension, benefits or payment because of an injury, sickness or disability?	❑	❑
14. Are you currently pregnant? If so, due date:	❑	❑

Section 3 For every "Yes" answer given above, please provide full details

Question No.	Nature of disorder	Date of first occurrence	Current status and treatment

Section 4 Declaration and Authorization

I hereby declare that I have read this statement and I certify that the answers recorded above are full, complete, true and consistent with the statements I have made. I have kept a duly completed and signed copy of this form. I understand that these answers shall be part of my application for insurance. I also understand that any misrepresentation or concealment on my part may void any coverage issued as a result of this application.

I hereby authorize SSQ, Life Insurance Company Inc., its mandatories and reinsurers, and ENCON Group Inc., as required for determining insurability and for insurance management, including claim settlement purposes:

a) to obtain information, solely to the extent required for processing my file, from any individual or corporation, or any public or parapublic organization which has personal information about me or about my dependents, according to the terms of the contract, including any physician or health care professional, any medical or paramedical facility, the Medical Information Bureau and any other insurer;
b) to only disclose the personal information that they may have about me or about my dependents, according to the terms of the contract, to the extent required, to such individual or organization; and
c) to use the necessary personal information contained in any other file already held by them which has been completed.

A photocopy of this authorization shall be as valid as the original. This authorization shall be valid only for the period necessary to effect the purposes stated herein.

Please sign here

Signature | Date (yyyy/mm/dd)

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Optional Benefits Enrollment Form

Section 1 Employee Information

Please print clearly

Name of Employer | Client No.

Name of Employee | Date of Birth (yyyy/mm/dd)

Name of Spouse | Date of Birth (yyyy/mm/dd)

Section 2 Benefit Selection

You may elect additional benefits for you or your family to supplement the amount of insurance provided under your group benefits program.

Optional Accidental Death & Dismemberment

1. Optional Accidental Death & Dismemberment coverage is available in increments of $25,000 to a maximum of $250,000. You may elect Employee Only or Family coverage.
2. The monthly premium for each $25,000 unit of Optional Accidental Death & Dismemberment is $0.80 for Employee Only coverage or $1.23 for Family coverage.

Optional Life and Spousal Optional Life

1. Optional Life and Spousal Optional Life is available in increments of $10,000 to a maximum of $250,000. All amounts of coverage are subject to satisfactory evidence of insurability before coverage will be made effective. Along with your request for Optional Life benefits, please complete and return an Application for Insurance for each applicant.
2. The monthly premium rates for each $10,000 unit of Optional Life or Spousal Optional Life are age-banded and are determined by the applicant's age and gender, and on a smoker/non-smoker basis, as set out in the following schedule.

Age	Male smoker	Male non-smoker	Female smoker	Female non-smoker
under 30	$0.82	$0.53	$0.57	$0.38
30-34	$0.91	$0.57	$0.67	$0.43
35-39	$1.14	$0.67	$0.86	$0.48
40-44	$1.91	$1.05	$1.29	$0.72
45-49	$3.34	$1.81	$2.15	$1.14
50-54	$5.48	$3.05	$3.34	$1.91
55-59	$9.05	$5.15	$5.10	$3.05
60-64	$13.11	$7.91	$7.05	$4.57

Section 3 Non-Smoker Declaration

I, the proposed insured, declare that I have not used any form of tobacco or cannabis in the last twelve months. I understand and agree that this declaration shall form part of the application and become part of any policy issued as a result of such application. The company will rely upon the truth of this declaration in issuing this policy. If a misstatement has been made in reference to the proposed insured's non-smoking status, then any benefit payment will be limited to a refund of the paid premium.

Name of Employee

Please sign here Employee Signature | Date (yyyy/mm/dd)

Name of Spouse

Please sign here Spouse Signature | Date (yyyy/mm/dd)

Section 4 Request for Coverage

I, the undersigned, hereby apply for the following amounts of optional coverage and authorize the necessary payroll deductions for participation in these employee paid benefits. I understand that the beneficiary(s) for these benefits will be as designated on my enrollment form and that I will be the beneficiary for any dependent benefits.

Optional Accidental Death & Dismemberment Amount $ | ❑ Employee Only Coverage ❑ Family Coverage

Optional Life Amount $

Spousal Optional Life Amount $

Please sign here Employee Signature | Date (yyyy/mm/dd)