



# 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

Other

1x annual earnings

2x annual earnings

3x annual earnings

#### Benefit Maximum

\$ \_\_\_\_\_

Select maximum up to \$500,000

*not required for flat benefit option*

**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
- Other

**Benefit Duration**

- 17 weeks
- 26 weeks
- 52 weeks

**Benefit Maximum**

\$ \_\_\_\_\_  
Select maximum up to \$1,000

**Long Term Disability**

**Benefit Options**

- 60% of salary
- 66 2/3% of salary
- 66 2/3% of first \$2,500, 45% thereafter
- Other

**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	<input type="checkbox"/> 3-4	<input type="checkbox"/> 5-9	<input type="checkbox"/> 10-24	<input type="checkbox"/> 25-34	<input type="checkbox"/> 35-50
Life NEM	\$100,000	\$150,000	\$200,000	\$250,000	\$300,000
LTD NEM	\$1,500	\$2,000	\$3,500	\$4,500	\$5,000
CI NEM	\$25,000	\$25,000	\$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

**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

- pay direct drug plan
- reimbursement drug plan

- 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**

- 80% reimbursement
- 100% reimbursement

**Benefit Maximum**

- \$1,000/year
- \$1,500/year

**Major Services**

- 50% reimbursement

**Benefit Maximum**

- \$1,000/year
- \$1,500/year combined with Basic Services
- \$2,000/year combined with Basic Services

**Orthodontia\***

- 50% reimbursement
- \*not available to 1-2 life groups

**Benefit Maximum**

- \$1,000 lifetime
- \$1,500 lifetime
- \$2,000 lifetime

**Deductible**

- nil
- \$25 single, \$50 family/year

**Annual Recall Options**

- 6 months
- 9 months
- 12 months

Other

**Optional Benefits**

**Optional Life**

**Benefit Options**

- employee
- spouse
- units of \$10,000

**Benefit Maximum**

\$250,000

**Optional Accidental Death & Dismemberment**

**Benefit Options**

- employee only
- employee and family
- units of \$25,000

**Benefit Maximum**

\$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**

- Life \_\_\_\_\_ %
- AD&D \_\_\_\_\_ %
- Dependent Life \_\_\_\_\_ %
- Weekly Indemnity \_\_\_\_\_ %

**Benefit**

**Employee Contribution**

- Long Term Disability \_\_\_\_\_ %
- Critical Illness \_\_\_\_\_ %
- Extended Health Care \_\_\_\_\_ %
- 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