Selectpac

Master Application

for groups with 3 to 35 plan members

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GROUP APPLICANT INFORMATION

Group Applicant's Name: *(Full Legal Name)* ______________________

Street Address: ______________________

City: ______________ Province: ______________ Postal Code: ______________

Telephone: (______) ______________ Fax: (______) ______________

Contact Person: ______________ Title: ______________

Email Address: ______________________

Language: ☐ English ☐ French ☐ New Group ☐ Amendment Policy No. ______________

GROUP POLICY INFORMATION

Total number of lives to be insured: ______________ Requested effective date: ______________

Please list any employees excluded from coverage under this policy, including reasons for exclusion:

____

____

____

The "Contract Location" is a location in Canada where the Group Applicant has accepted the Group Policy. Any requirement for Great-West Life to charge GST / HST is based on the Contract Location. The Group Applicant address must always represent this "Contract Location".

Does this policy have Non Refund drug coverage? ☐ Yes ☐ No

If Yes, is the **EP3** Statement attached to the Master Application? ☐ Yes ☐ No

If No, what is the reason?
- ☐ To follow
- ☐ Drug coverage was Refund or ASO with previous carrier
- ☐ Group did not have drug coverage previously

BILLING DIVISION INFORMATION
(Complete if more than one division)

Division No.: ______________ Division Name: ______________

Description: ______________________

Billing/Administration address: ☐ Same as policy address ☐ Other (please specify below)

Street Address: ______________________

City: ______________ Province: ______________ Postal Code: ______________

Telephone: (______) ______________ Fax: (______) ______________

Contact Person: ______________ Title: ______________

Email Address: ______________________

SUBSIDIARY/AFFILIATED FIRM INFORMATION

Please list subsidiaries/affiliated firms to be insured under and identified in the policy.

1. ______________________
2. ______________________
3. ______________________

POLICY INFORMATION

Previous Carrier (if transfer group): ______________________________

Number of Years In-force: ____________________ Previous Policy Number: ______________________________

Termination Date (of Previous Carrier): ______________________________

If transferring from another carrier:

- **attach/arrange for a list of employees who have satisfied their deductibles for this calendar year.**
- **If there was LTD coverage with the prior carrier and LTD is included with this group, it is important that the client keep a copy of the LTD contract from their most recent carrier, as it may be used to assess the pre-existing limitation on any claims.**

ADMINISTRATION INFORMATION

Hours normally worked per week: ☐ 40 ☐ 37.5 ☐ 35 ☐ Other, please specify: ____________

The minimum number of weekly hours an employee must work in order to be eligible for coverage is:
☐ 24 hours ☐ Other (greater than 24 hours), please specify: ______________________________

Are seasonal employees to be insured for coverage on the effective date of this plan? ☐ Yes ☐ No

NOTE: Seasonal employees must work nine out of 12 months to be eligible for coverage.

Are independent contractors to be insured for coverage on the effective date of this plan? ☐ Yes ☐ No

NOTE: Certain restrictions in coverage to independent contractors will apply.

Are blue collar employees eligible for STD and/or LTD coverage on this plan? ☐ Yes ☐ No

If Yes, are all of those blue collar employees covered by a Workers' Compensation or similar plan? ☐ Yes ☐ No

Are regular overtime and bonuses to be included as earnings? ☐ Yes ☐ No

Waiting Period For:	**All Existing Employees**	**All Employees Hired After Effective Date**
	☐ no waiting period	☐ no waiting period
	☐ months ________*	☐ months ________*

**Waiting periods are applied to an employee's date of full time employment (see form #M5544).*

On the effective date of this plan, will any employees be age 65 or over and working and residing in the province of Quebec? ☐ Yes ☐ No

NOTE: Employees age 65 or over who live and work in Quebec are eligible for RAMQ drug coverage. If these employees waive RAMQ coverage, they must be specifically identified and set up in a separate class to allow for proper drug claims adjudication.

ADMINISTRATION MATERIALS

The Plan Administration Guide, Contracts and Employee Booklets will be provided to the policyholder in an electronic format.

SPECIAL HANDLING OF SPECIFIED EMPLOYEES

Are there any employees expected to be absent from work because of injury, sickness or leave of absence on the requested effective date? ☐ Yes ☐ No

If yes, complete the following:

Employee's Name	Date Sickness began or Injuries Occurred	Nature of Absence

MEDICAL REIMBURSEMENT PLAN APPLICATION

We apply to Great-West Life for Medical Reimbursement Plan (MRP) as described below. (Only provide address and contact information if it differs from page one of this application.)

Address: ____________________

City: ____________________ Province: ____________________ Postal Code: __________

Telephone: (_______) ____________________ Fax: (_______) ____________________

Contact person to whom routine correspondence is directed: ____________________

Title: ____________________

Eligibility

Employees eligible for MRP are classified as: ____________________

☐ These eligible employees are described as a separate benefit class under your group policy. All employees listed under this benefit class are entitled to the MRP.

☐ These eligible employees are **not** described as a separate benefit class under your group policy. All employees must be identified in writing by the plan sponsor.

Participants eligible for MRP are listed below.

____________________ ____________________

____________________ ____________________

____________________ ____________________

____________________ ____________________

____________________ ____________________

Eligibility for MRP benefits is determined by the group policyholder.

Benefits

Per person annual maximum:

☐ $ ____________________ (Increments of $100 to a maximum of $1,000)

☐ $ ____________________ (Increments of $1,000 to a maximum of $50,000)

☐ Healthcare covered expenses (including Visioncare Services and Supplies)

☐ Healthcare covered expenses (excluding Visioncare Services and Supplies)

☐ Dentalcare covered expenses

THE Great-West Life ASSURANCE COMPANY

Copy of the Terms and Conditions Business Pre-Authorized Debit (PAD) Agreement

To be given to Group Policyholder

Group Policyholder Name (Full Legal Name): ______________________________

Group Policy Number(s): ______________________________

Division Number(s): ______________________________

☐ Healthcare Spending Account ☐ Medical Reimbursement Plan

Effective date of first withdrawal: ______________________________

Monthly withdrawal day (choose from 1 - 28): __________________

Important note(s): **If there is a different bank account or monthly withdrawal date, a separate form is required. Please provide this PAD agreement and an unsigned blank cheque marked "VOID" to your Great-West group representative.** The completed PAD agreement must be received by Great-West Life's GROUP INSURANCE PAYMENT ADMINISTRATION department **at least 14 days prior to the first withdrawal day**.

Terms and Conditions of PAD Agreement	
Authorization	**Note:** References in this form to "this PAD agreement" include later amendments to it. Reference in this PAD agreement to "we" and "our" refers to the Group Policyholder (Payor) indicated above. We authorize The Great-West Life Assurance Company (Great-West) and the financial institution named above (or any other financial institution we may authorize at any time) to withdraw from our account any payments that we have agreed to make under the listed above group policy(ies), and/or as otherwise specified to be made in this PAD agreement as though we had personally signed a cheque. We understand that changes to the Group Policy(ies) including as applicable, to premium amounts or to the method or required amount of payment (including changes requested to this PAD agreement) or termination and recommencement of automatic payments under this PAD agreement may increase or decrease the amount withdrawn or to be withdrawn from our account. **Accordingly, we authorize such increases or decreases, waiving any pre-notification requirement with respect to them.** We agree that a photocopy or electronic copy of this PAD agreement will be as valid as the original.
Signatures	We certify that all persons whose signatures are required to authorize this PAD agreement have signed below, including any required joint account holder.
Account changes	We will notify Great-West if our financial institution, branch or account number changes. To continue withdrawals without interruption, notice of any change is required 14 days before the change effective date. Great-West may, but is not obligated to, rely on verbal instructions from us to amend this authorization.
Confirming withdrawals	We agree to regularly review our account information and if we question or disagree with the amount withdrawn or any account changes, we will notify Great-West in writing within 10 days of the withdrawal or account changes; otherwise, we agree that the withdrawal or account changes will be considered to have been properly made. For questions related to these withdrawals we may contact Great-West.
Non-sufficient funds (NSF) information	If there is not enough money in our account to cover the total amount due ("due" as an amount owing, or as an amount otherwise specified to be withdrawn under this PAD agreement), we authorize Great-West to immediately make a second attempt to withdraw the amount due (which may be greater than the amount due at the first attempt). If the second attempt is also returned NSF (or if Great-West decides, in its sole discretion, not to make the second attempt), we understand that pre-authorized payments will be suspended, and possibly cancelled by Great-West. We understand that we are responsible for any NSF charge(s).
Assignment	**We hereby waive any requirement of prior written notice to us by Great-West of the assignment by Great-West of this PAD agreement.**
Cancellation	This PAD agreement may be cancelled if any withdrawal is not permitted or is reversed by the financial institution, or upon 30 days written notice given by us to Great-West or by Great-West to us. To obtain a sample cancellation form, or for more information on your right to cancel this PAD agreement, contact your financial institution or visit www.cdnpay.ca. To obtain more information on your PAD agreement, contact your Great-West representative. We agree that if pre-authorized payments are suspended, the method of payment may automatically be changed by Great-West, in its sole discretion, to whatever it then offers on a non pre-authorized debit basis. Great-West, in its sole discretion, may require a new written PAD agreement if this PAD agreement is cancelled for any reason.
Recourse	We have certain recourse rights if any debit does not comply with this PAD agreement. For example, we have the right to receive reimbursement for any debit that is not authorized or is not consistent with this PAD agreement. To obtain information on our recourse rights, we may contact our financial institution or visit www.cdnpay.ca.
Contact information	For more information about this PAD agreement, contact Great-West at selectpacPAD@gwl.ca or contact to us at The Great-West Life Assurance Company - Group Insurance Payment Administration, PO Box 1053 Winnipeg MB R3C 2X4, or call 1-204-946-2905.

THE Great-West Life ASSURANCE COMPANY

Business Pre-authorized Debit (PAD) Agreement

(Available for Canadian currency only)

Group Policyholder Name (Full Legal Name): ______________________

Group Policy Number(s): ______________________

Division Number(s): ______________________

☐ Healthcare Spending Account ☐ Medical Reimbursement Plan

Effective date of first withdrawal: ______________________

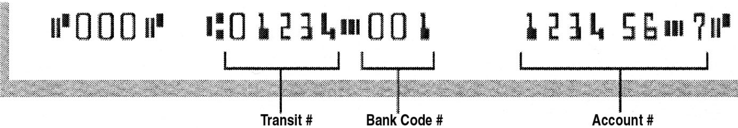
Monthly withdrawal day (choose from 1 - 28): __________

Name and address of Financial Institution:

____

____

Transit Number: __________ Bank Code: __________ Account Number: __________



Important note(s): **If there is a different bank account or monthly withdrawal date, a separate form is required. Please provide this PAD agreement and an unsigned blank cheque marked "VOID" to your Great-West group representative.** The completed PAD agreement must be received by Great-West Life's GROUP INSURANCE PAYMENT ADMINISTRATION department **at least 14 days prior to the first withdrawal day**.

PAYOR (Please type or print clearly)

Group Policyholder Name (Full Legal Name):

____

____

Name(s), Title(s), Signature(s) and Phone Number(s) of Authorized Signing Officers:

Name of Authorized Signing Officer: ______________________

Title: ______________________

Signature: ______________________

Date: ______________________

Phone Number: ______________________

Name of Authorized Signing Officer: ______________________

Title: ______________________

Signature: ______________________

Date: ______________________

Phone Number: ______________________

Name, Title, Signature and Phone Number of Joint Account Holder (if applicable):

Name: ______________________

Title: ______________________

Signature: ______________________

Date: ______________________

Phone Number: ______________________

To *apply* for Group Insurance:

We, the previously mentioned Group Applicant, apply to THE GREAT-WEST LIFE ASSURANCE COMPANY for the group coverage described in this application.

We acknowledge and agree that the attached quotation forms a part of this application.

We agree that no insurance will take effect until all of the following conditions have been met:

1. This application must be accepted and the effective date approved by Great-West Life at its Head Office;
2. A binder premium must be paid; and
3. The minimum participation requirements must be met.

WE DECLARE that all statements, representations and answers made in this application are consideration for and a basis of the contract(s) of insurance between us and Great-West Life. We declare these statements, representations and answers to be true, full and complete. We agree that no other statement, representation or information will be binding upon or affect the rights of Great-West Life. We agree to give Great-West Life, on request, full information on each employee insured or eligible for insurance, including information required for assessment of claims.

Please complete the date and signature section below.

To *amend* your Group Insurance:

We, the previously mentioned Group Applicant, apply to THE GREAT-WEST LIFE ASSURANCE COMPANY for amendment of our Group Policy Number ______________________ . We request that the amendment be effective: ________________________________ .

We acknowledge and agree that the attached quotation forms a part of this application.

WE AGREE that:

1. Increases in benefits only take effect when an employee is actively at work. If a dependant is confined in hospital on the date an increase would otherwise take effect, it will not take effect until the date of discharge from hospital.
2. A policy amendment is valid and takes effect as of the effective date approved by Great-West Life only if:
   a) It is made according to the application; and
   b) It is signed by an executive officer of Great-West Life and by or for the actuary of Great-West Life.

WE DECLARE that all statements, representations and answers made in this application are a consideration for and a basis of the requested amendment(s). We declare these statements, representations and answers to be true, full and complete. We agree that no other statement, representation or information will be binding upon or affect the rights of Great-West Life. We agree to give Great-West Life, on request, full information on each employee insured or eligible for insurance, including information required for assessment of claims.

Please complete the date and signature section below.

Dated at ________________________ this ____________________ day of ________________________ , ________________________
(Province) (Day) (Month) (Year)

Group Applicant ____
(PRINT NAME & TITLE)

Advisor's Name (please print) ____

______________________________ ______________________________
(ADVISOR'S SIGNATURE) (GROUP APPLICANT'S SIGNATURE)

GroupNet for Plan Administration Access Agreement

In consideration of The Great-West Life Assurance Company (Great-West) granting

____

Group Policyholder

access to and use of Great-West's GroupNet™ for Plan Administration website (GroupNet)

The Group Policyholder hereby agrees as follows:

1. This Agreement applies to all group policies in effect as at the date of acceptance of this Agreement by Great-West and to any group policy issued to the Group Policyholder by Great-West while this Agreement remains in effect.
2. The Group Policyholder will provide Great-West with a list of its employees and agents which may include without limitation producers, consultants and third party administrators, if applicable who require access to GroupNet for the purposes of plan administration and whom the Group Policyholder has authorized in writing to access GroupNet (the "User"). The Group Policyholder will keep such list current and indicate for each User whether any access restrictions are to apply in respect to GroupNet's Enrollment, Billing or Experience/Claims functions. The Group Policyholder agrees that its authorization shall be deemed to have been given to Great-West to provide the Group Policyholder's broker/consultant with access to GroupNet's Experience/Claims functions as a User. The Group Policyholder further agrees to notify Great-West immediately by sending written notice to its local Great-West office in the event that a User's access to GroupNet is to be terminated or restricted.
3. The Group Policyholder and Users are granted access to GroupNet only for the purpose of administering the Group Policy and will not use information obtained through GroupNet for any other purpose. The Group Policyholder is responsible for keeping and causing the Users to keep the information obtained through GroupNet confidential and is responsible for any misuse or unauthorized disclosure by the Group Policyholder or its Users.
4. The Group Policyholder authorizes Great-West to act upon any instructions and enter any information that may be provided by Users relating to the Group Policy. Great-West reserves the right to refuse a User access to GroupNet.
5. The Group Policyholder accepts responsibility and agrees that Great-West will have no liability for any and all access to and use of GroupNet by the Users, including without limitation any unauthorized access and use after the User's access has been terminated and any access to and use of GroupNet by any other person using a User's name and/or password.
6. The Group Policyholder will indemnify and hold Great-West harmless for and from any claims, losses, costs and damages arising out of or resulting from any access or use by the Group Policyholder, Users or by any other person using the User's name and/or password.
7. The Group Policyholder agrees to be bound by the terms and conditions set out in the GroupNet Legal, Copyright and Trademark information section contained on the GroupNet website (www.groupnet.gwl.ca), as amended from time to time, and agrees that such terms and conditions shall apply to all use of GroupNet by Users. The Group Policyholder shall be responsible for any breach of such terms and conditions by it or any User or any other person using a User's name and/or password.
8. The Group Policyholder and Users may not assign this Agreement. Great-West reserves the right to terminate the Group Policyholder's or any User's right to access and use GroupNet at any time. This Agreement shall survive the termination of the Group Policyholder's and the User's right to access and use GroupNet and shall survive the expiry or termination of the Group Policy.
9. The Group Policyholder agrees that it will and will cause Users to comply with all applicable laws, including any laws governing the use of personal information.
10. The terms "Group Policy" and "Group Policyholder" in this Agreement may be interpreted as "group contract(s)", "Group Contract" and "Group Contractholder" respectively where this Agreement is used in connection with an Administrative Services Only (ASO) plan.
11. This Agreement may be executed by one or more of the parties by facsimile transmitted signature and the parties agree that the reproduction of the signatures by way of facsimile device will be treated as though such reproductions were executed originals.

Accepted and Agreed to by:

____

(Name of Group Policyholder)

Per: ____

____

Name (printed)

____

Date

Accepted and Agreed to by:

The Great-West Life Assurance Company

Per: ____

____

Name (printed)

____

Date

GREAT-WEST GROUPNET

CLIENT USER ACCESS FORM

For each GroupNet Client User, please complete and sign this form and forward it to your local Great-West contact. A facsimile of this authorization is as valid as the original.

Forms will not be accepted unless authorized by the Group Policyholder and a Great-West contact. If you need help completing these forms, please call the GroupNet Help Desk at 1-800-665-2648 or your Great-West group representative.

Please allow the GroupNet Help Desk five business days for processing.

Please Print

Group Policyholder Name ______________________

Delete User

Name ______________________

☐ Immediate
☐ Once new user is added

Existing GroupNet User Name/ID ______________________

Add User

Name *(include middle initial)* ______________________

Title: ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ ______________________

Language Preference: ☐ English ☐ French Existing GroupNet User Name/ID (if any): ______________________

Internet Email Address: ______________________

Check the GroupNet Functions Required

Policy Number(s)	Division(s) 'All' or specify	Experience & Claims	Billing	Medical Reimbursement Plan Billing	Healthcare Spending Account Billing	Enrollment 'All' functions	*OR Specify Enrollment Functions*				
							Add	Terminate	Revise	Great-West Assisted Changes	Inquire
		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Change information for Existing GroupNet User

Name ______________________ Existing GroupNet User Name/ID ______________________

Internet Email Address ______________________

Add	Delete	Policy Number(s)	Division(s) 'All' or specify	Experience & Claims	Billing	Medical Reimbursement Plan Billing	Healthcare Spending Account Billing	Enrollment 'All' functions	*OR Specify Enrollment Functions*				
									Add	Terminate	Revise	Great-West Assisted Changes	Inquire
☐	☐			☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
☐	☐			☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

***For Internal Use Only* - Advisor Information** (for access to Experience and Claims only; otherwise complete the Advisor User Access Form - Enrollment and/or Billing).

Advisor Name ______________________ Existing GroupNet User Name/ID ______________________

Authorized by Group Policyholder: ______________________ Date: ______________________

Authorized by local Great-West contact: ______________________ Date: ______________________

Group Office/Sales and Marketing Centre: ______________________

Note to the local Great-West contact*: Submit completed forms to:* ***GroupNet and ClienTel Administration, 4W.***

GREAT-WEST GROUPNET

MANAGE BILL PAYMENTS - USER ACCESS FORM

For clients using pre-authorized debit

The GroupNet Manage Bill Payment feature is available for Clients who have completed a Pre-Authorized Debit (PAD) Agreement and submitted it to Great-West Life.

Important: Completion of this form will enable the person authorized below to revise the amount to be withdrawn and/or change the date of the withdrawal (to a date earlier than the originally scheduled withdrawal date).

For each GroupNet user, please complete and sign this form and forward it to your local Great-West contact. A facsimile of this authorization is as valid as the original.

Forms will not be accepted unless authorized by the Group Policyholder and a Great-West contact. If you need help completing these forms, please call the GroupNet Help Desk at 1-800-665-2648 or your Great-West contact.

Please allow the GroupNet Help Desk five business days for processing.

Please Print

____
Group Policyholder Name

Manage Bill Payments

Name: ______________________________

Existing GroupNet User Name/ID: ______________________________ (if any)

Internet Email Address: ______________________________

Add	Delete	Policy Number(s)	Division(s) 'All' or specify	Pay Head Office Bill	Pay Medical Reimbursement Plan Bill	Pay Health Spending Account Bill
☐	☐			☐	☐	☐
☐	☐			☐	☐	☐

Authorized by Group Policyholder: ______________________________ Date: ______________

Authorized by local Great-West contact: ______________________________ Date: ______________

Group Office/Sales and Marketing Centre: ______________________________

Note to the local Great-West contact: Submit completed forms to: **GroupNet and ClienTel Administration, 4W.**