Master Application for Group Insurance

Please ensure all pages of this form are completed in full. If more than 1 class is required, attach additional pages.

COMPANY INFORMATION

Legal Company Name

Company Address

Street _____

City _____ Province _____ Postal Code _____

Phone ( ) _____ Fax ( ) _____

Contact Name

Contact Email Address

Nature of Business

☐ Corporation ☐ Partnership
☐ Proprietorship ☐ Other

☐ Union
Class(es) _____
☐ Non-Union

Associated or Affiliated Companies

_____

Will they require a separate billing statement? ☐YES ☐NO

Number of Employees Eligible

Number of Employees Enrolled

Employee Classes Not Covered

Are all participants covered by Workers Compensation Benefits? ☐YES ☐NO If no, please indicate which individuals do not have the coverage: _____

Present Carrier

Policy Number

Cancellation Date

Please include a copy of the prior carrier billing statement for the month immediately preceding the effective date of this plan.

EMPLOYEES NOT ACTIVELY AT WORK

Are any employees disabled or not actively at work? (personal leave, maternity leave, lay-off etc.) ☐ YES ☐ NO
Do you have any reason to believe that any of the employees and/or their dependents are not healthy? ☐ YES ☐ NO

If "Yes" to either of the above, please provide the following details (attach separately if additional space is required):

NAME	REASON NOT ACTIVELY AT WORK	DATE LAST WORKED	EXPECTED RETURN TO WORK DATE	LIFE WAIVER APPROVAL
				☐ YES ☐ NO
				☐ YES ☐ NO
				☐ YES ☐ NO

A **GroupSource** ***Enrollment Card*** is required for all employees not actively at work.

GroupSource

Suite 200, 5970 Centre Street SE, Calgary, Alberta T2H 0C1
Telephone (403) 228-1644 *Fax* (403) 228-1968 *Toll-free* 1-800-661-6195

PLAN INCEPTION DETAILS

Plan Effective Date: _____ , 20 _____

First Month's Premium Deposit: $ _____

Binder cheque is not deposited until the application is approved. A void cheque must also be attached for PAD.

GENERAL PROVISIONS

New employees are eligible after _____ months of continuous employment (plan waiting period).

Is the waiting period to be waived for all employees hired on or before plan effective date? ☐ YES ☐ NO

Employees are eligible when actively working a minimum of _____ hours per week.

EMPLOYER / EMPLOYEE CONTRIBUTION (%)

	LIFE	AD&D	CI	DEP LIFE	STD	LTD	EHC	DENTAL	EAP	OPT LIFE	OPT AD&D
Employer											
Employee											

HEALTH SPENDING ACCOUNT (HSA)

Is a Health Spending Account (HSA) required? *(separate form is required)* ☐ YES ☐ NO

COST PLUS

Is Cost Plus required? *(separate form is required)* ☐ YES ☐ NO

OFFICE USE ONLY

Renewal Block _____

PLAN DESIGN DETAILS

Class _____

Description: _____

BASIC LIFE and ACCIDENTAL DEATH, DISEASE & DISMEMBERMENT

☐ Flat Amount $_____

or

☐ _____times annual earnings

N.E.M. $ _____

Maximum $ _____

Termination ☐ Age 70

☐ _____

Reduction _____% at Age _____

Life Rate $_____/1,000

AD&D Rate $_____/1,000

SHORT TERM DISABILITY

☐ Not Required

Funding Arrangements

☐ Insured ☐ ASO *Administrative Services Only*

☐ Non-Taxable ☐ Taxable

Schedule	Start*	Duration
☐ 60%	☐ 1-4-1	☐ 17 Weeks
☐ 66 2/3%	☐ 1-8-1	☐ 15 Weeks
☐ 70%	☐ 15-15-15	☐ 26 Weeks
		☐ 52 Weeks

Maximum $ _____

Termination ☐ Age 70

☐ _____

*Benefits Start:
Accident, Illness, Hospitalization (must be hospitalized 24 hours or more)

STD Rate $_____/10

CRITICAL ILLNESS

☐ Not Required

Flat Amount $_____

Termination ☐ Age 65

☐ Age 70

CI Rate $_____/1,000

DEPENDENT LIFE

☐ Not Required

☐ $5,000 Spouse / $2,500 Child

☐ $10,000 Spouse / $5,000 Child

☐ $20,000 Spouse / $10,000 Child

Termination ☐ Age 70

☐ _____

Dep Life Rate $_____

LONG TERM DISABILITY

☐ Not Required

☐ Non-Taxable ☐ Taxable

Schedule	Elimination Period	Maximum Benefit Duration
☐ 60%	☐ 17 Weeks	☐ 2 Years
☐ 66 2/3%	☐ 26 Weeks	☐ 5 Years
☐ 70%	☐ Other _____	☐ Age 65

Own Occupation Period ☐ 2 years ☐ _____

☐ 2 tier graded _____% of the first $ _____
plus _____% of the remainder

☐ 3 tier graded _____% of the first $ _____
plus _____% of the next $_____ plus
_____% of the remainder

N.E.M. $ _____

Maximum $ _____

(Coverage ceases at age 65)

LTD Rate $_____/100

PLAN DESIGN DETAILS

Class _____

Description: _____

EXTENDED HEALTH CARE

☐ Not Required

Funding Arrangements

☐ Insured ☐ ASO
Administrative Services Only

Stop Loss Pooling *(for ASO plans only)*

☐ $10,000 ☐ $25,000 ☐ _____

Deductible **(Per Calendar Year)**

Single / Family

☐ Nil ☐ $25 / $25 ☐ $25 / $50 ☐ _____

Drug Plan Deductible

☐ Nil ☐ $ _____ / Rx ☐ Dispensing Fee
☐ Dispensing Fee Cap $ _____

Drugs

☐ Reimbursement ☐ Pay Direct

Co-insurance

☐ 80% Drugs / 80% Other
☐ 80% Drugs / 100% Other
☐ 100% Drugs / 100% Other
☐ _____

Limitations (Pay Direct only)

☐ None ☐ Managed Formulary
☐ Standard Generic Substitution
Plan pays generic drug unless specified on prescription "no substitutions"
☐ Mandatory Generic Substitution
Plan pays generic drug regardless if prescription states "no substitutions"

Vision Care ☐ Nil ☐ 80% ☐ 100% ☐ _____

Maximum:
☐ $150 ☐ $200 ☐ $250 ☐ $300 ☐ _____

Termination ☐ Age 70
☐ _____

EHC Special Notes: _____

DENTAL CARE

☐ Not Required

Funding Arrangements

☐ Insured ☐ ASO
Administrative Services Only

Deductible **(Per Calendar Year)**

Single / Family

☐ Nil ☐ $25 / $25 ☐ $25 / $50 ☐ _____

Co-insurance

Basic	Major	Orthodontic
☐ 100%	☐ Nil	☐ Nil
☐ 80%	☐ 50%	☐ 50%
☐ _____	☐ _____	☐ _____

Calendar Year Maximums*

Basic

☐ Unlimited ☐ $1,000 ☐ $1,500 ☐ $2,000

Major

☐ $1,000 ☐ $1,500 ☐ $2,000 ☐ $2,500

OR

Combined Basic and Major

☐ $1,000 ☐ $1,500 ☐ $2,000 ☐ $2,500

Orthodontic ***Orthodontic Maximums are Per Lifetime**

☐ $1,000 ☐ $1,500 ☐ $2,000 ☐ $2,500

Termination ☐ Age 70
☐ _____

Dental Special Notes: _____

Dental Rates
Single: $ _____
Family: $ _____

EHC Rates **(incl. Emerg. Travel)**
Single: $ _____
Family: $ _____

Vision Care Rates
Single: $ _____
Family: $ _____

Stop Loss Rates **(incl. Emerg. Travel)**
Single: $ _____
Family: $ _____

ASO Rates
Single: $ _____
Family: $ _____

PLAN DESIGN DETAILS

Class _____

Description: _____

OPTIONAL LIFE INSURANCE

Available in units of $10,000 or $25,000 to a maximum of $500,000 per insured individual. All amounts of Optional Life Insurance are subject to **Evidence of Insurability**. Underwritten by The Co-operators.

Is Optional Life required? ☐ **Yes** ☐ **No**

Was this a benefit on your prior plan? ☐ **Yes** ☐ **No**

Standard GroupSource *Optional Life rates apply*

OPTIONAL ACCIDENTAL DEATH & DISMEMBERMENT

Available in units of $10,000 or $25,000 to a maximum of $500,000 per insured individual. All amounts of Optional Accidental Death & Dismemberment Insurance are subject to **Evidence of Insurability**. Underwritten by The Co-operators.

When combined with the Basic Accidental Death, Disease and Dismemberment coverage, the combined total under both plans may not exceed $1,200,000.

Is Optional AD&D required? ☐ **Yes** ☐ **No**

Was this a benefit on your prior plan? ☐ **Yes** ☐ **No**

Standard GroupSource *Optional AD&D rates apply*

EMPLOYEE AND FAMILY ASSISTANCE PROGRAM (EFAP)

Provided by Shepell.fgi

Is EFAP required? ☐ **Yes** ☐ **No**

EFAP Rate $ _____

General Plan Design Special Notes:

APPLICANT DECLARATION

We the undersigned hereby certify that to the best of our knowledge, the information provided on this application is accurate and true. We acknowledge that if the application is approved, the coverage will become effective on the date indicated. We understand and agree to provide all necessary information for the sound administration of the policy and to pay all premiums and contributions necessary to maintain the group benefits applied for herein. In addition, no Agent has the power on behalf of the Insurance Company to make or modify an application for insurance, or to bind said Company by making any promise or representation or by giving or receiving any information. We further understand that a policy will be issued by:

SSQ Financial Group

- ☐ Life
- ☐ Dependent Life
- ☐ STD
- ☐ LTD
- ☐ Extended Health Care
- ☐ Dental Care

The Co-operators

- ☐ Life
- ☐ AD&D
- ☐ Dependent Life
- ☐ STD
- ☐ LTD
- ☐ Extended Health Care
- ☐ Dental Care
- ☐ Optional Life
- ☐ Optional AD&D

SSQ Insurance Company Inc.

- ☐ Critical Illness
- ☐ Emergency Travel Assistance

Fenchurch General Insurance Company

- ☐ LTD

and will accept all provisions, limitations and exclusions within said policy.

DATED AT _____ ON _____ 20 _____

_____
(FULL CORPORATE NAME)

BY _____
(AUTHORIZED SIGNATURE)

_____
(PRINT NAME AND TITLE)

_____
AGENT/BROKER AGENT/BROKER SIGNATURE

AGENT/BROKER INFORMATION

Name: _____ Phone: _____

Email: _____ Fax: _____

PRE-AUTHORIZED DEBIT (PAD) PLAN AGREEMENT

We authorize GroupSource and the financial institution designated to begin withdrawals as per our instructions for the monthly regular recurring payments, and/or one-time payments from time to time for payment of all charges arising under our GroupSource account(s). Regular monthly payments for the full amount of services delivered will be debited to our specified account on the day of the month chosen below. We will receive details on the amount of Pre-Authorized Debit via our monthly premium statement(s).

This authority is to remain in effect until GroupSource has received written notification from us of its change or termination. This notification must be received at least ten (10) business days before the next debit is scheduled at the address provided below. We may obtain a sample cancellation form or more information on our right to cancel a PAD Agreement at our financial institution or by visiting www.cdnpay.ca.

We have certain recourse rights if any debit does not comply with this agreement. For example, we have the right to receive reimbursement for any PAD that is not authorized or is not consistent with this PAD Agreement. Should we have any questions or concerns regarding this PAD agreement we may contact GroupSource directly.

Legal Company Name _____

Affiliate Companies _____

Street _____

City _____ Province _____ Postal Code _____

Phone ( ) _____ Fax ( ) _____ Email _____

Type of Service: Business

Please attach a VOID cheque or confirmation of pre-authorized debit information form from your financial institution.

Financial Institution (FI) _____

FI Transit Number ___ ___ ___ ___ ___ / ___ ___ ___
Branch - 5 digits FI - 3 digits

Account Number _____

Payment Start Date _____ (payment start date is only required for existing policies. For new policies, the first PAD withdrawal will be the month following the binder premium cheque).
Account will be debited on the 10th of each month.

Signature(s) of Authorized Representative(s) _____ _____

Print Name(s) of Authorized Representative(s) _____ _____

Title(s) of Authorized Representative(s) _____ _____

Dated at: _____ on _____ 20 _____

GroupSource
Suite 200, 5970 Centre Street SE, Calgary, Alberta T2H 0C1
Telephone (403) 228-1644 *Fax* (403) 228-1968 *Toll-free* 1-800-661-6195

GroupSource Online
USER REGISTRATION ASSIGNMENT / PERMISSIONS

Legal Company Name ______________________________

Print Name of Authorized Representative ______________________________

Print Title of Authorized Representative ______________________________

I hereby authorize the following access for the Registered Plan Administrator(s) listed:

Registered Plan Administrator (user) ____________________ Email Address ____________________

Company Accesses	Employee Changes	Monthly Statement
☐ All Companies in Policy	☐ View Only ***OR*** ☐ Add/Change	☐ View Billing
☐ Specific Companies only (list below)		
____________________	☐ View Only ***OR*** ☐ Add/Change	☐ View Billing
____________________	☐ View Only ***OR*** ☐ Add/Change	☐ View Billing
____________________	☐ View Only ***OR*** ☐ Add/Change	☐ View Billing

Registered Plan Administrator (user) ____________________ Email Address ____________________

Company Accesses	Employee Changes	Monthly Statement
☐ All Companies in Policy	☐ View Only ***OR*** ☐ Add/Change	☐ View Billing
☐ Specific Companies only (list below)		
____________________	☐ View Only ***OR*** ☐ Add/Change	☐ View Billing
____________________	☐ View Only ***OR*** ☐ Add/Change	☐ View Billing
____________________	☐ View Only ***OR*** ☐ Add/Change	☐ View Billing

Registered Plan Administrator (user) ____________________ Email Address ____________________

Company Accesses	Employee Changes	Monthly Statement
☐ All Companies in Policy	☐ View Only ***OR*** ☐ Add/Change	☐ View Billing
☐ Specific Companies only (list below)		
____________________	☐ View Only ***OR*** ☐ Add/Change	☐ View Billing
____________________	☐ View Only ***OR*** ☐ Add/Change	☐ View Billing
____________________	☐ View Only ***OR*** ☐ Add/Change	☐ View Billing

A valid email address is required for each user to access GroupSource Online. Should there be a change of Registered Plan Administrator or a change of email address, please immediately advise your Co-ordinator, Client Services or your Administrator, Administrative Services.

Signature of Authorized Representative ______________________________

Dated at: ____________________ on ____________________ 20 ____________________

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