



Master Application Group Insurance

1. APPLICANT INFORMATION

Name of Group Applicant _____
Full Legal/Corporate Name

- Corporation
 Partnership
 Sole Proprietorship
 Unionized (provide copies of relevant collective agreements)
 Other _____

Name(s) of Affiliates/Subsidiaries _____

Head Office Address _____
No. and Street

_____ City _____ Province _____ Postal Code

Describe Nature of Business _____

2. CURRENT GROUP COVERAGE

- No current group coverage
 Yes, current group coverage, _____ total lives currently insured, per the following:

Benefit	Carrier/Provider	Planned Termination Date*
<input type="checkbox"/> Basic Life		
<input type="checkbox"/> AD&D		
<input type="checkbox"/> Dependent Life		
<input type="checkbox"/> Short Term Disability		
<input type="checkbox"/> LTD		
<input type="checkbox"/> Extended Health		
<input type="checkbox"/> Dental		

*Do not terminate existing coverage until notice is received that RWAM has approved the desired replacement coverage

- Are any employees currently excluded from group coverage? No Yes (attach list & reasons excluded)
- Are any employees currently excluded from WSIB/WCB coverage? No Yes (attach list & reasons excluded)
- Are any dependents currently covered for survivor benefits? No Yes (attach list with expiry dates of coverage)

3. DESIRED GROUP COVERAGE

Coverage Effective Date _____ (Rates are guaranteed for the first 15 months unless alternate arrangements have been approved)

No. of lives to be insured _____ No. of lives ineligible or to be excluded from group coverage _____

Waiting Period for all benefits _____ days

All eligible employees Actively at Work on the Coverage Effective Date are covered immediately, unless otherwise stated.

4. ELIGIBILITY REQUIREMENTS

- Minimum hours per week _____ hours (standard minimum is 24 hrs per week)
- Only permanent employees, non-seasonal, who regularly work the minimum hours per week are eligible for group insurance
- Insurable earnings for all benefits **exclude** dividends, bonuses, profit sharing, and other extra compensation
- Contract employees are subject to written approval by RWAM. Are there contract employees you wish to be included?
 No Yes. If Yes, list below, detailing occupation, length of formal contract, method of remuneration:



5. PARTICIPATION*

*Minimum 3 life requirement

- Contributory group (Employees contribute some premiums. Employer contribution must be at least 50% of total premiums)
75% Participation required in all benefits
- Non-Contributory group (Employees contribute NO premiums. Employer contribution is 100% of total premiums)
Life & Dependent Life employer-paid premiums are taxable employee benefits. Any disability benefits are taxable.
100% Participation required in all benefits
- Group is *under* 10 lives
100% Participation required in all benefits

6. EMPLOYEES NOT ACTIVELY AT WORK

The Applicant understands and agrees that all benefits are available only to those employees who are Actively Working on the group's Coverage Effective Date. For those employees who are **not** Actively at Work on the Coverage Effective Date, their coverage under certain benefits may be either limited or ineligible (e.g. disability coverage may be ineligible), until their return to Active Work.

The following employees are not Actively at Work as of the date of this Application (attach list if more room required):

Name of Employee	Reason not Actively at Work <small>(e.g. leave of absence, maternity, layoff, work/auto accident, disability claim*)</small>	Date Last Worked	Expected Return Date	*Status of Disability Claim	*Status of Group Life Waiver
				<input type="radio"/> Pending <input type="radio"/> Approved	<input type="radio"/> Pending <input type="radio"/> Approved
				<input type="radio"/> Pending <input type="radio"/> Approved	<input type="radio"/> Pending <input type="radio"/> Approved
				<input type="radio"/> Pending <input type="radio"/> Approved	<input type="radio"/> Pending <input type="radio"/> Approved
				<input type="radio"/> Pending <input type="radio"/> Approved	<input type="radio"/> Pending <input type="radio"/> Approved

***Attach details confirming the status of any employee's disability claim** for any current or *anticipated* disability claims under a group insurance *life waiver* benefit and/or LTD benefit with an existing insurer, with WCB/WSIB, or with an auto insurer, including names of the insurance carriers.

Please ensure that employees not Actively at Work are still given an enrolment form to complete and submit. Some limited benefits may be available to absent employees, subject to the nature of coverage and the plan's terms and provisions.

NOTE: If RWAM is not provided with the name of an employee who is not Actively at Work as of the date this Application is signed, or if RWAM is not provided immediate notification of an employee who has ceased to be Actively at Work between the date this Application is signed and the date of acceptance of this Application, the insurer reserves the right to decline such employee's coverage.

7. ELIGIBLE DIVISIONS & CLASSES

Division (1,2,3)	Name of Division <small>(Separate divisions receive separate billings*)</small>	Class (A,B,C)	Description of Class of Employees <small>(Employee classes within each Division**)</small>

*If each Division has a separate billing address, attach details

**Employee classes are eligible for differing plan designs



A - BENEFITS

1. EMPLOYEE BASIC LIFE INSURANCE

Div (1,2,3)	Class (A,B,C)	Flat Amount	or	Multiple of Annual Earnings*	Maximum without Evidence (NEM)	Maximum with Evidence	Termination Age
		<input type="checkbox"/> \$ _____		<input type="checkbox"/> _____ times earnings	\$ _____	\$ _____	<input type="radio"/> Age 65 <input type="radio"/> Age 70**
		<input type="checkbox"/> \$ _____		<input type="checkbox"/> _____ times earnings	\$ _____	\$ _____	<input type="radio"/> Age 65 <input type="radio"/> Age 70**
		<input type="checkbox"/> \$ _____		<input type="checkbox"/> _____ times earnings	\$ _____	\$ _____	<input type="radio"/> Age 65 <input type="radio"/> Age 70**

*Rounded to the next higher \$1000

**Basic Life Volume Reduces 50% at age 65

2. EMPLOYEE ACCIDENTAL DEATH & DISMEMBERMENT

Div (1,2,3)	Class (A,B,C)	Equals Basic Life Amount	or	Multiple of Basic Life Amount*	Maximum without Evidence (NEM)	Maximum with Evidence	Termination Age
		<input type="checkbox"/> Equals Basic Life		<input type="checkbox"/> 2 times Basic Life	\$ _____	\$ _____	<input type="radio"/> Age 65 <input type="radio"/> Age 70**
		<input type="checkbox"/> Equals Basic Life		<input type="checkbox"/> 2 times Basic Life	\$ _____	\$ _____	<input type="radio"/> Age 65 <input type="radio"/> Age 70**
		<input type="checkbox"/> Equals Basic Life		<input type="checkbox"/> 2 times Basic Life	\$ _____	\$ _____	<input type="radio"/> Age 65 <input type="radio"/> Age 70**

*Rounded to the next higher \$1000

**AD&D Volume Reduces 50% at age 65

† **Critical Illness Benefit?** No Yes, Rider 1: cancer only

or

Rider 2: cancer, heart attack, kidney failure, and stroke

(† Offered only by ACE INA)

3. DEPENDENT LIFE

Div (1,2,3)	Class (A,B,C)	Option Selection* (Spousal coverage cannot exceed employee's Basic Life amount)		
		<input type="checkbox"/> Spouse \$5,000/Child \$2,500	<input type="checkbox"/> Spouse \$10,000/Child \$5,000	<input type="checkbox"/> Spouse \$20,000/Child \$10,000
		<input type="checkbox"/> Spouse \$5,000/Child \$2,500	<input type="checkbox"/> Spouse \$10,000/Child \$5,000	<input type="checkbox"/> Spouse \$20,000/Child \$10,000
		<input type="checkbox"/> Spouse \$5,000/Child \$2,500	<input type="checkbox"/> Spouse \$10,000/Child \$5,000	<input type="checkbox"/> Spouse \$20,000/Child \$10,000

*Dependent Life terminates at maximum age 70



4. EMPLOYEE LONG TERM DISABILITY

Div (1,2,3)	Class (A,B,C)	% of Monthly Income*	or Graded LTD Benefit Formula*	Maximum without Evidence (NEM)	Maximum with Evidence
		_____ %	_____ % of first \$ _____ of monthly income _____ % of next \$ _____ of monthly income _____ % of remaining monthly income	\$ _____	\$ _____
		_____ %	_____ % of first \$ _____ of monthly income _____ % of next \$ _____ of monthly income _____ % of remaining monthly income	\$ _____	\$ _____
		_____ %	_____ % of first \$ _____ of monthly income _____ % of next \$ _____ of monthly income _____ % of remaining monthly income	\$ _____	\$ _____

*Rounded to the next higher \$1.00

Div (1,2,3)	Class (A,B,C)	Taxable or Non-Taxable*		LTD Elimination Period			Own Occupation or Any Occupation**		
		<input type="radio"/> Taxable	<input type="radio"/> Non-Taxable	<input type="checkbox"/> 17 weeks	<input type="checkbox"/> 26 weeks	<input type="checkbox"/> Other _____	<input type="radio"/> 1 yr	<input type="radio"/> 2 yr	<input type="checkbox"/> Any Occ
		<input type="radio"/> Taxable	<input type="radio"/> Non-Taxable	<input type="checkbox"/> 17 weeks	<input type="checkbox"/> 26 weeks	<input type="checkbox"/> Other _____	<input type="radio"/> 1 yr	<input type="radio"/> 2 yr	<input type="checkbox"/> Any Occ
		<input type="radio"/> Taxable	<input type="radio"/> Non-Taxable	<input type="checkbox"/> 17 weeks	<input type="checkbox"/> 26 weeks	<input type="checkbox"/> Other _____	<input type="radio"/> 1 yr	<input type="radio"/> 2 yr	<input type="checkbox"/> Any Occ

*Non-Taxable - Employees in class must all pay 100% of their LTD premiums & applicable taxes

Div (1,2,3)	Class (A,B,C)	Maximum Benefit Duration	COLA	
		<input type="checkbox"/> Benefits expire at age 65 <input type="checkbox"/> Benefits expire at earlier of 5 yrs or age 65 <input type="checkbox"/> Benefits expire at earlier of 2 yrs or age 65	<input type="radio"/> No COLA	<input type="radio"/> Yes at _____ %
		<input type="checkbox"/> Benefits expire at age 65 <input type="checkbox"/> Benefits expire at earlier of 5 yrs or age 65 <input type="checkbox"/> Benefits expire at earlier of 2 yrs or age 65	<input type="radio"/> No COLA	<input type="radio"/> Yes at _____ %
		<input type="checkbox"/> Benefits expire at age 65 <input type="checkbox"/> Benefits expire at earlier of 5 yrs or age 65 <input type="checkbox"/> Benefits expire at earlier of 2 yrs or age 65	<input type="radio"/> No COLA	<input type="radio"/> Yes at _____ %

- Primary Offsets for CPP/QPP (i. e. benefits for dependent children are excluded from offset) are standard
- Direct Offsets for WCB/WSIB are standard
- LTD Coverage Termination Age is earlier of retirement or age 65

Special LTD Request: _____

(NOTE: Requests are subject to review by RWAM for confirmation of availability/ability to accommodate)



5. SHORT TERM DISABILITY (STD)

SELF-INSURED ASO (If SELF-INSURED, complete the 'ASO Checklist - Self-Insured Short Term Disability' form)

or

If to be INSURED, complete remainder of this section:

Div (1,2,3)	Class (A,B,C)	STD Benefit Formula	Maximum STD Benefit	Partial Week*	First Day STD is Payable		
					Hospital	Accident	Sickness
		_____ %	\$ _____	<input type="radio"/> 1/5 <input type="radio"/> 1/7	_____	_____	_____
		_____ %	\$ _____	<input type="radio"/> 1/5 <input type="radio"/> 1/7	_____	_____	_____
		_____ %	\$ _____	<input type="radio"/> 1/5 <input type="radio"/> 1/7	_____	_____	_____

*A partial week's benefit can be calculated based on one-fifth or one-seventh of the STD benefit amount payable for a full week.

Div (1,2,3)	Class (A,B,C)	Taxable or Non-Taxable*		Maximum Duration of STD Benefit
		<input type="radio"/> Taxable	<input type="radio"/> Non-Taxable	<input type="checkbox"/> 17 weeks <input type="checkbox"/> 26 weeks <input type="checkbox"/> Other _____ weeks
		<input type="radio"/> Taxable	<input type="radio"/> Non-Taxable	<input type="checkbox"/> 17 weeks <input type="checkbox"/> 26 weeks <input type="checkbox"/> Other _____ weeks
		<input type="radio"/> Taxable	<input type="radio"/> Non-Taxable	<input type="checkbox"/> 17 weeks <input type="checkbox"/> 26 weeks <input type="checkbox"/> Other _____ weeks
		<input type="radio"/> Taxable	<input type="radio"/> Non-Taxable	<input type="checkbox"/> 17 weeks <input type="checkbox"/> 26 weeks <input type="checkbox"/> Other _____ weeks

*Non-Taxable - Employees in class must all pay 100% of their STD premiums & applicable taxes

- STD is reduced by any WCB/WSIB payable if work related sickness/accident
- STD Coverage Termination Age is earlier of retirement or age 65

Special STD Request:

(NOTE: Requests are subject to review by RWAM for confirmation of availability/ability to accommodate)



6. EXTENDED HEALTH CARE

- SELF-INSURED ASO (If SELF-INSURED, complete the 'ASO Checklist - Self-Insured Extended Health Care' form)
 Health Spending Account (If HSA, complete the HSA 'Stand Alone' or 'Top Up' Application form)

or

- If to be INSURED, complete remainder of this section:

Div (1,2,3)	Class (A,B,C)	EHC Calendar Year Deductible*	Coverage Termination Age*	Survivor Benefit
		<input type="checkbox"/> Nil <input type="checkbox"/> Single \$_____ Family \$_____	<input type="radio"/> Age 75 <input type="radio"/> Other age:_____	<input type="checkbox"/> 24 mos
		<input type="checkbox"/> Nil <input type="checkbox"/> Single \$_____ Family \$_____	<input type="radio"/> Age 75 <input type="radio"/> Other age:_____	<input type="checkbox"/> 24 mos
		<input type="checkbox"/> Nil <input type="checkbox"/> Single \$_____ Family \$_____	<input type="radio"/> Age 75 <input type="radio"/> Other age:_____	<input type="checkbox"/> 24 mos

*Coverage terminates at retirement date, if that date is earlier than the Termination Age

i) Drug Plan Electives

- Prescription Drug Plan** is limited to items which legally require a prescription & are dispensed by a pharmacist.
 - The Standard Prescription Drug Plan covers cost of the lowest priced equivalent generic drug, *unless* the physician specifies "no substitution".
 - An optional control of 'Mandatory Product Selection' can be chosen, which limits coverage to cost of the lowest priced equivalent generic drug, *regardless* of whether the physician specifies "no substitution".
The 'Mandatory Product Selection' option requires the use of a drug card.
- Prescribed Drug Plan** allows items if they are prescribed by a licensed physician or dentist & are dispensed by pharmacist
- Provincial Drug Formulary Plan** requires the use of a drug card and is limited to the formulary of the provincial drug plan

Div (1,2,3)	Class (A,B,C)	Drug Co-insurance	Drug Plan Choice
		_____ %	<input type="checkbox"/> Prescription Drug Plan ~ <input type="radio"/> Standard Plan or <input type="radio"/> Mandatory Product Selection option <input type="checkbox"/> Prescribed Drug Plan <input type="checkbox"/> Provincial Drug Formulary ~ Province: _____
		_____ %	<input type="checkbox"/> Prescription Drug Plan ~ <input type="radio"/> Standard Plan or <input type="radio"/> Mandatory Product Selection option <input type="checkbox"/> Prescribed Drug Plan <input type="checkbox"/> Provincial Drug Formulary ~ Province: _____
		_____ %	<input type="checkbox"/> Prescription Drug Plan ~ <input type="radio"/> Standard Plan or <input type="radio"/> Mandatory Product Selection option <input type="checkbox"/> Prescribed Drug Plan <input type="checkbox"/> Provincial Drug Formulary ~ Province: _____

Div (1,2,3)	Class (A,B,C)	Drug Deductible Options	Dispensing Fee Cap Option	Individual Maximum Options	Combined Family Calendar Year Maximum Option
		<input type="radio"/> \$ _____ <input type="radio"/> Deductible = Dispensing Fee	\$ _____	<input type="radio"/> \$ _____ per calendar year <input type="radio"/> \$ _____ per lifetime	\$ _____
		<input type="radio"/> \$ _____ <input type="radio"/> Deductible = Dispensing Fee	\$ _____	<input type="radio"/> \$ _____ per calendar year <input type="radio"/> \$ _____ per lifetime	\$ _____
		<input type="radio"/> \$ _____ <input type="radio"/> Deductible = Dispensing Fee	\$ _____	<input type="radio"/> \$ _____ per calendar year <input type="radio"/> \$ _____ per lifetime	\$ _____

Standard Prescription and Prescribed Drug plans include:

- Diabetic supplies, including monitoring devices and disposable needles for administering insulin
- Oral contraceptives
- Allergy serums
- Fertility drugs, limited to 50% co-insurance with a \$2500 lifetime maximum
- Erectile Dysfunction (ED) drugs, limited to 50% co-insurance with a \$600 per calendar year maximum



6. Continued - EXTENDED HEALTH CARE

ii) General EHC Benefits

Div (1,2,3)	Class (A,B,C)	*General EHC Co-insurance	Include Private Duty Nursing? ○ No ○ Yes, per below	Include Hearing Aids? ○ No ○ Yes, per below
		_____ %	○ \$10,000 per calendar yr / \$25,000 lifetime ○ Other _____	○ \$400 every 5 calendar years ○ Other _____
		_____ %	○ \$10,000 per calendar yr / \$25,000 lifetime ○ Other _____	○ \$400 every 5 calendar years ○ Other _____
		_____ %	○ \$10,000 per calendar yr / \$25,000 lifetime ○ Other _____	○ \$400 every 5 calendar years ○ Other _____

*General EHC Co-insurance applies to all standard benefits listed, including private duty nursing & hearing aids

General EHC Benefits include:

- Medical Equipment: Eligible expenses include rental or purchase (per insurer's determination) of manual wheelchair, non-electrical hospital bed, TENS unit, aerosol equipment, mist tent, traction apparatus, mozes detector, insulin pump, CPAP unit.

Apply overall maximum to Medical Equipment?

○ Yes, \$ _____ calendar yr max ○ Yes, \$ _____ lifetime max

- Medical Services & Supplies: Eligible expenses include initial costs of *physician prescribed* casts, splints, braces (excluding dental braces), crutches, cervical collars, ostomy supplies, oxygen supply; medically required surgical brassieres (2 per yr), surgical stockings (2 pairs per yr), wigs (\$200 Lifetime max); glucometers, glucoscans, tube feeding supplies
- Prosthetics, limited to a \$25,000 lifetime maximum for initial placement only of non-myoelectric limbs, artificial eyes
- Cardiac Rehabilitation, maximum \$500 per calendar year
- RNCP Nutritional consulting at \$150 per calendar year
- Dental Accidents
- Optional private duty nursing, optional hearing aids

iii) Paramedical Benefits? No Yes, per following:

\$500 per calendar year maximum per Practitioner Other \$ _____ per calendar year maximum per Practitioner

Maximums per following Practitioners:

Div (1,2,3)	Class (A,B,C)	Paramedical Co-insurance*	Acupuncturist, Psychologist/Social Worker (MSW), Osteopath, Naturopath, Chiropractor, Podiatrist†
		_____ %	\$ _____ per year
		_____ %	\$ _____ per year
		_____ %	\$ _____ per year

- Per Year means per calendar year per insured individual
- For Chiropractor† or Podiatrist† service, depending on the province, do you want benefits payable from the first dollar?
○ Yes ○ No

*Paramedical Co-insurance applies to ALL Paramedical Electives chosen for a Division/Class

Div (1,2,3)	Class (A,B,C)	Chiropractor†	Registered Massage Therapist	Physiotherapist	Speech Therapist
		○ \$ _____ per visit ○ \$ _____ per year ○ 15 visit deductible	○ \$ _____ per visit ○ \$ _____ per year ○ Require physician's referral	○ \$ _____ per visit ○ \$ _____ per year	○ \$ _____ per visit ○ \$ _____ per year
		○ \$ _____ per visit ○ \$ _____ per year ○ 15 visit deductible	○ \$ _____ per visit ○ \$ _____ per year ○ Require physician's referral	○ \$ _____ per visit ○ \$ _____ per year	○ \$ _____ per visit ○ \$ _____ per year
		○ \$ _____ per visit ○ \$ _____ per year ○ 15 visit deductible	○ \$ _____ per visit ○ \$ _____ per year ○ Require physician's referral	○ \$ _____ per visit ○ \$ _____ per year	○ \$ _____ per visit ○ \$ _____ per year



6. Continued - EXTENDED HEALTH CARE

iv) Hospital Benefits? No Yes, per following:

Div (1,2,3)	Class (A,B,C)	Hospital Co-insurance*	Semi-Private or Private	Include Convalescent Hospital – 180 days**	Apply EHC Calendar Year Deductible
		_____ %	<input type="checkbox"/> <input type="checkbox"/>	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes
		_____ %	<input type="checkbox"/> <input type="checkbox"/>	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes
		_____ %	<input type="checkbox"/> <input type="checkbox"/>	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes

*Hospital Co-insurance applies to Convalescent Hospital if elected

**Convalescent is semi-private only

v) Orthotics Benefits? No Yes, per following:

Div (1,2,3)	Class (A,B,C)	Orthotic Inserts	Orthotic Shoes	Option Combined Calendar Year Maximum
		Co-insurance \$ _____ % <input type="radio"/> \$ _____ per year max <input type="radio"/> Max _____ pair per year	Co-insurance \$ _____ % <input type="radio"/> \$ _____ per year max <input type="radio"/> Max _____ pair per year	<input type="radio"/> \$ _____ per year
		Co-insurance \$ _____ % <input type="radio"/> \$ _____ per year max <input type="radio"/> Max _____ pair per year	Co-insurance \$ _____ % <input type="radio"/> \$ _____ per year max <input type="radio"/> Max _____ pair per year	<input type="radio"/> \$ _____ per year
		Co-insurance \$ _____ % <input type="radio"/> \$ _____ per year max <input type="radio"/> Max _____ pair per year	Co-insurance \$ _____ % <input type="radio"/> \$ _____ per year max <input type="radio"/> Max _____ pair per year	<input type="radio"/> \$ _____ per year

vi) Vision Benefits? No Yes, per following:

Div (1,2,3)	Class (A,B,C)	Vision Co-insurance†	Vision Maximum Corrective Glasses/Contacts and Medically Required Contacts	Laser Eye Surgery*	Apply EHC Calendar Year Deductible
		_____ %	Adult \$ _____ per _____ mos Child \$ _____ per _____ mos, max age _____ <input type="radio"/> Include medically required contacts	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes
		_____ %	Adult \$ _____ per _____ mos Child \$ _____ per _____ mos, max age _____ <input type="radio"/> Include medically required contacts	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes
		_____ %	Adult \$ _____ per _____ mos Child \$ _____ per _____ mos, max age _____ <input type="radio"/> Include medically required contacts	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes

*Standard Laser Eye Surgery Benefit is lifetime maximum of 2X Adult Vision max

Div (1,2,3)	Class (A,B,C)	Eye Exams
		<input type="radio"/> Reasonable & customary cost of one exam every 24 mos or <input type="radio"/> Adult \$ _____ per _____ mos Child \$ _____ per _____ mos, max child age _____
		<input type="radio"/> Reasonable & customary cost of one exam every 24 mos or <input type="radio"/> Adult \$ _____ per _____ mos Child \$ _____ per _____ mos, max child age _____
		<input type="radio"/> Reasonable & customary cost of one exam every 24 mos or <input type="radio"/> Adult \$ _____ per _____ mos Child \$ _____ per _____ mos, max child age _____

†Vision Co-insurance applies to Eye Exams

Adult/Child max options must be within reasonable & customary parameters

Special EHC Requests: _____

(NOTE: Requests are subject to review by RWAM for confirmation of availability/ability to accommodate)



7. EHC STOP LOSS INSURANCE per INSURED INDIVIDUAL

If EHC Benefit IS SELF-INSURED ASO, complete Stop Loss section on the 'ASO Checklist - Self-Insured Extended Health Care' form

If EHC Benefit is INSURED, complete remainder of this section:

- If group is **less** than 75 lives, Stop Loss = \$7,500 per year
- If group is 75 lives or **more** select:
 - Nil or \$10,000 per year

Are there any insureds with recurring EHC claims that have exceeded the selected Stop Loss level? No Yes

NOTE:

In the event of non-disclosure prior to issuance of Stop Loss coverage that an individual's actual past EHC claim amounts have exceeded the selected Stop Loss level, then notwithstanding that coverage is already in effect, RWAM shall have the right to *exclude* such individual's excess claim amounts under the Stop Loss policy. All excluded claims will be the responsibility of the Applicant.

8. OUT-OF-PROVINCE/OUT-OF-CANADA INSURANCE

OOB Benefits per following:

- Co-insurance is 100%
- Maximum OOB emergency coverage is \$2 million
- Optional medical referral coverage is \$50,000 maximum
- Standard 60 days coverage

Div (1,2,3)	Class (A,B,C)	OOB Emergency Coverage?	Include Medical Referral?
		<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="radio"/> No <input type="radio"/> Yes
		<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="radio"/> No <input type="radio"/> Yes
		<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="radio"/> No <input type="radio"/> Yes

Special OOB Request:

(NOTE: Requests are subject to review by RWAM for confirmation of availability/ability to accommodate)

9. MISCELLANEOUS BENEFITS

- Employee Assistance Program
- Critical Illness \$_____ volume of coverage per employee
- WorldCare
- Group Optional Life
- Group Optional AD&D



10. DENTAL CARE

- SELF-INSURED ASO (If SELF-INSURED, complete the 'ASO Checklist - Self-Insured Dental Care' form)
 Health Spending Account (If HSA, complete the HSA 'Stand Alone' or 'Top Up' Application form)
 or
 If to be INSURED, complete remainder of this section:

i) Dental Plan Electives

Div (1,2,3)	Class (A,B,C)	○ Basic & Preventative Co-insurance	○ Major Restorative Co-insurance	○ Orthodontic Co-insurance
		_____ %	_____ %	_____ %
		_____ %	_____ %	_____ %
		_____ %	_____ %	_____ %

Div (1,2,3)	Class (A,B,C)	Dental Calendar Year Deductible*	Coverage Termination Age*	Survivor Benefit
		<input type="checkbox"/> Nil <input type="checkbox"/> Single \$ _____ Family \$ _____	<input type="radio"/> Age 75 <input type="radio"/> Other age: _____	<input type="checkbox"/> 24 mos
		<input type="checkbox"/> Nil <input type="checkbox"/> Single \$ _____ Family \$ _____	<input type="radio"/> Age 75 <input type="radio"/> Other age: _____	<input type="checkbox"/> 24 mos
		<input type="checkbox"/> Nil <input type="checkbox"/> Single \$ _____ Family \$ _____	<input type="radio"/> Age 75 <input type="radio"/> Other age: _____	<input type="checkbox"/> 24 mos

*Coverage terminates at retirement date, if that date is earlier than the Termination Age

ii) Fee Guide & Recall

Div (1,2,3)	Class (A,B,C)	Dental Fee Guide Year	Recall
		<input type="checkbox"/> Current <input type="checkbox"/> Other _____	<input type="radio"/> 6 mos <input type="radio"/> 9 mos <input type="radio"/> 12 mos
		<input type="checkbox"/> Current <input type="checkbox"/> Other _____	<input type="radio"/> 6 mos <input type="radio"/> 9 mos <input type="radio"/> 12 mos
		<input type="checkbox"/> Current <input type="checkbox"/> Other _____	<input type="radio"/> 6 mos <input type="radio"/> 9 mos <input type="radio"/> 12 mos

iii) Benefit Maximum Electives (Option A cannot be combined with Option B)

Div (1,2,3)	Class (A,B,C)	OPTION A			OPTION B*
		Basic Per Individual	Major Per Individual	Orthodontic Per Individual	Combined Calendar Year Maximum* Basic, Major, & Orthodontic
		\$ _____ per year	\$ _____ per year <input type="radio"/> Max for Major only <input type="radio"/> Max combined with Basic	<input type="radio"/> \$ _____ per year <input type="radio"/> \$ _____ lifetime max	Individual Max \$ _____ Family Max \$ _____
		\$ _____ per year	\$ _____ per year <input type="radio"/> Max for Major only <input type="radio"/> Max combined with Basic	<input type="radio"/> \$ _____ per year <input type="radio"/> \$ _____ lifetime max	Individual Max \$ _____ Family Max \$ _____
		\$ _____ per year	\$ _____ per year <input type="radio"/> Max for Major only <input type="radio"/> Max combined with Basic	<input type="radio"/> \$ _____ per year <input type="radio"/> \$ _____ lifetime max	Individual Max \$ _____ Family Max \$ _____

*If choosing Option B, there is NO lifetime maximum on Orthodontic. Combined maximum is based on employee's Single or Family coverage.

Special Dental Request:

(NOTE: Requests are subject to review by RWAM for confirmation of availability/ability to accommodate)



B - RATES

BENEFIT	Div (1,2)	Class (A,B)	RATE	CARRIER/PROVIDER
<input type="checkbox"/> Basic Life (per \$1000)			\$ _____	_____
<input type="checkbox"/> AD&D (per \$1000)			\$ _____	_____
<input type="checkbox"/> Dependent Life			\$ _____	_____
<input type="checkbox"/> LTD (per \$100)			\$ _____	_____
<input type="checkbox"/> Short Term Disability (per \$10)			\$ _____	<input type="radio"/> _____ <input type="radio"/> Self-insured ASO
<input type="checkbox"/> Extended Health			Single \$ _____ Family \$ _____	<input type="radio"/> _____ <input type="radio"/> Self-insured ASO
<input type="checkbox"/> Stop Loss			Single \$ _____ Family \$ _____	_____
<input type="checkbox"/> Out-of-Canada/Province			Single \$ _____ Family \$ _____	Mondial
<input type="checkbox"/> Dental			Single \$ _____ Family \$ _____	<input type="radio"/> _____ <input type="radio"/> Self-insured ASO
<input type="checkbox"/> EAP Plan			\$ _____	Ceridian Canada Ltd.
<input type="checkbox"/> WorldCare			\$ _____	WorldCare
<input type="checkbox"/> Critical Illness			\$ _____	ACE INA



C - ADMINISTRATION

Authorized Plan Administrator Name Title

Contact Information Plan Administrator's Phone No. Plan Administrator's Fax No. Plan Administrator's confidential e-mail address

Group Premium Billing Options:

- Send invoices by regular mail or Send electronically to above e-mail address of authorized Plan Administrator
Use RWAM's Pre-Authorized Debit (PAD) service to pay monthly premiums? No Yes

IF 'Yes', complete the following Pre-Authorized Debit (PAD) Agreement:

Name of Financial Institution
Account No
Branch Transit No. Financial Institution No.

<< ATTACH A VOID CHEQUE along with the initial premium deposit accompanying this application >>

P.A.D. Authorization:

I authorize RWAM Insurance Administrators Inc. (RWAM) to debit the bank account identified above and/or shown on the attached void cheque for all monthly invoiced premiums (variable amount) and any applicable taxes on or about the 1st business day of every month...

I have waived the right to pre-notification of at least 10 days before my first PAD; however RWAM will send me monthly written invoices identifying any new premium amount/rate change at least 10 days before each and any change in the amount of my PAD.

My authorization may be revoked at any time in writing, subject to providing a notice period of 30 days to RWAM. To obtain a sample cancellation form or for information on my right to cancel a PAD agreement, I may contact my financial institution or visit www.cdnpay.ca.

I understand I have certain recourse rights if any debit does not comply with this agreement. For example, I have the right to receive reimbursement for any debit that is not authorized or is not consistent with this PAD agreement. If I wish to obtain more information on my recourse rights, I may contact my financial institution or visit www.cdnpay.ca.

These services are for (check one): Business Use Personal Use

Authorized Signature X Date

Authorized Signature X Date
If joint account, additional signature required

Payment of Employee Benefits Options:

- Use EFT (Electronic Funds Transfer) (ensure each employee completes the Electronic Deposit form, including whether to send EOB to home or personal e-mail address)
Send to the home address of all employees, addressed Private & Confidential to the employee in a sealed envelope (ensure each employee's home address information is provided on their enrolment form)
Send care/of employer's address, addressed Private & Confidential in individual sealed envelopes to each employee for distribution (ensure sealed envelopes are not opened by anyone except the employee to whom addressed)



D - APPLICATION TO PARTICIPATE IN THE RWAM TRUST

WHEREAS:

- (a) The Applicant desires to obtain the benefits requested in this Application for its eligible employees and their eligible dependents, and hereby applies to become a Participating Employer under the Retailers, Wholesalers and Manufacturers Group Insurance Trust (the "RWAM Trust");
(b) The agreement governing the RWAM Trust (the "RWAM Trust Agreement") provides that the trustees of the said trust, or their authorized agents, shall have the right and discretion to accept or reject applications from qualified persons to become Participating Employers in the said trust from time to time;
(c) Benefits provided by licensed insurers under group insurance contracts issued to the Trustees of the RWAM Trust (the "Trustees") include: Extended Health Care, Dental, Out-of-Province/Out-of-Canada coverage, group Life Insurance, Accidental Death & Dismemberment benefits, Long Term Disability benefits, Short Term Disability benefits, and other optional group insurance products;
(d) RWAM Insurance Administrators Inc. ("RWAM") is the authorized agent of the Trustees of the RWAM Trust, and has been appointed as administrator of the RWAM Trust.

NOW THEREFORE, subject to the Applicant being accepted as a Participating Employer in the RWAM Trust, THE APPLICANT ACKNOWLEDGES, UNDERTAKES AND AGREES:

- 1. To be bound by all the terms, provisions, conditions and limitations of the RWAM Trust Agreement and any and all insurance contracts issued to the Trustees and all lawful amendments thereto;
2. To pay, or cause to be paid, all contributions and premiums necessary to provide the benefits applied for herein, or subsequently requested, as and when due. (Premiums are due on the 1st day of each month.)
3. That the only benefits provided shall be in accordance with this Application as submitted. Any changes desired by the Applicant must be requested in writing and are subject to the approval of the Trustees or their authorized agent, and shall only be effective as of the date of such approval.
4. To hold open for inspection any records in its possession or under its control relating to this Application and the benefits hereby applied for or provided hereunder, and to co-operate fully with the Trustees, RWAM and their agents in all matters regarding the benefits applied for or provided.
5. At all times, to enroll only actively working, eligible permanent employees and their eligible dependents for benefit coverage.
6. To immediately inform RWAM in writing of any changes to the Contributory or Non-Contributory status of its employees' premiums or contributions, including any changes affecting the status, for tax purposes, of any benefits provided for under this Application.
7. To provide immediate written notification to RWAM of any employee who ceases to be Actively at Work between the date this Application is signed and the date of acceptance of this Application.
8. To provide RWAM with at least 30 days prior written notice of its intent to terminate its participation hereunder, failing which RWAM in its discretion may require payment of the full month's premium or may charge a 15 % late notice fee.

The Applicant hereby appoints RWAM Insurance Administrators Inc. to act as its agent under the RWAM Trust Agreement, to act on the Applicant's behalf for the purposes of the said trust agreement, including, without limitation, any notice provisions or amendments thereto, save and except for any notice of default as to contributions or premiums, or any notice of termination as a Participating Employer.

The Applicant hereby declares that, to the best of the Applicant's knowledge, the statements and answers contained in this Application are full, complete and true as of the date hereof.

If this Application is approved, the effective date of coverage in respect of the benefits hereby applied for shall be the Coverage Effective Date indicated in this Application.

In the event any errors or omissions are discovered in this Application, RWAM is hereby authorized to amend this Application by noting the required change(s) on this Application. A copy of this amended Application shall be sent forthwith to the Applicant, and such action shall constitute acceptance of such change(s), unless the Applicant provides immediate written notice to the contrary.

An initial Premium Deposit of one month's premium is included with this Application.

Dated at _____ this _____ day of _____ 20____

Applicant (Full Legal/Corporate Name of Group Applicant)

Signed (Authorized Signatory for Applicant) Print Name & Title

Witness signature (or second Authorized Signatory for Applicant) Print Name & Title

Agent's Signature Print Name & Agency

RWAM INSURANCE ADMINISTRATORS INC.

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www.rwam.com