

1. APPLICANT INFORMATION

Corporation Partnership Sole Proprietorship
 Other _____

Corporate Legal Name (in full) _____

No. and Street _____ Business E-mail address _____

City, Province _____ Postal Code _____ Business Telephone (include area code) _____

Plan Administrator's Name and Title _____ Business Fax (include area code) _____

Nature of Business (describe fully) _____

No. of years in business _____ years Name(s) of any Affiliates/Subsidiaries _____

2. CURRENT GROUP COVERAGE (DO NOT TERMINATE CURRENT COVERAGE UNTIL APPROVAL IS CONFIRMED)

Is this application to replace similar group benefits? No Yes, complete the following:

Number of lives currently insured _____ Current benefits _____

Name of Carrier(s) _____ Planned termination date of existing coverage (Attach details if date differs by benefit)

3. ELIGIBILITY REQUIREMENTS

- Only **permanent** employees, non-seasonal, who are regularly and Actively Working a minimum 24 hours per week are eligible
- **100% participation** of all employees in the '1two3' Plan is required
- Applicant's business must be established and active for a **minimum one year**
- For groups less than 3 lives, all benefits are subject to medical underwriting & all employees must complete a **Medical Questionnaire**. If an employee is declined coverage, the entire group application may be declined.
- Some occupations are not eligible for LTD coverage due to the nature of the risk.

4. EFFECTIVE DATE & WAITING PERIOD

Coverage Effective Date _____ # Lives to be insured: 1 2 3 4 5
Year Month Day

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

Waiting Period for new employees: 3 mos 6 mos (Minimum Waiting Period is 3 months continuous employment)

5. PREMIUM CONTRIBUTIONS

- Non-Contributory - Employer pays 100% of all premiums *Contributory - Employees pay a portion of premiums
- *NOTE:** Choose 'Contributory' if **non-taxable** LTD benefits are desired. In order to qualify any disability plan for non-taxable benefits, **all** employees must pay 100% of their disability premiums & applicable taxes.

6. MANDATORY BENEFITS

Life	AD&D	Dependent Life	EHC	Out-of-Province/Canada
\$25,000	\$50,000	Spouse \$5,000 Child \$2,500	80% Co-insurance Survivor Benefit – 6 mos Single or Family	60 days / 100% Co-insurance \$2 million maximum Emergency Only (no medical referral)

Life and AD&D volumes reduce by 50% at age 65. All the above coverages terminate at the **earlier** of retirement or maximum age 70, if still Actively Working.

EXTENDED HEALTH CARE BENEFITS SUMMARY (All benefits are subject to provisions of the group insurance policy/benefit plan)

Benefit	Maximum
Prescription Drug Plan	\$2,000/yr/person
Practitioners	\$400/yr/practitioner (Chiropractor-\$20/visit)
Private Duty Nursing	\$10,000 lifetime maximum
Hearing Aids	\$400/5 yrs
Dental Accident	\$2,000 lifetime maximum

Benefit	Maximum
Eye Exams	1 exam/24 mos (\$50 maximum)
Orthotics/Orthopedic Shoes	\$250/yr
Medical Supplies, Ambulance	No \$ limit (Subject to usual & customary)
Cardiac Rehabilitation	\$500/yr
Prosthetics	\$10,000 lifetime maximum

EHC EXCLUSIONS: Hospital benefit (semi or private); Fertility, smoking cessation, & obesity drugs/treatment; Preventative vaccines

7. OPTIONAL BENEFITS (Optional Benefits also require 100% participation)

Basic & Preventative Dental Care? No Yes

Long Term Disability? No Yes, Taxable Non-Taxable*

<ul style="list-style-type: none"> 80% co-insurance, based on the current year's Dental Fee Guide for employee's province of residence Maximum \$1000 per calendar year, per person Recall not more than once every 9 months Includes routine oral examinations, bitewing x-rays, scaling, polishing, fluoride applications, fillings, space maintainers, extractions, denture repairs, endodontics, and periodontics (periodontal scaling/root planing 8 units per calendar year) Survivor Benefit – 6 months 	<ul style="list-style-type: none"> 60% of monthly insured earnings to a maximum of \$1500 per month, to earliest of recovery, retirement, or expiry at age 65 Insurable earnings exclude dividends, bonuses, profit sharing, and other extra compensation LTD payable after satisfying a 119 day (17 week) elimination period One Year Own Occupation definition of Total Disability (Any Occupation applicable after 12 months of LTD benefits) Primary CPP/QPP Offset and 85% All-Source Maximum Choice of Benefit Taxability. Check option desired above
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*NOTE: If Non-Taxable LTD benefit is desired, all Employees must pay 100% of LTD premiums & applicable taxes.

8. PREMIUM SUMMARY – Cost per month

MANDATORY BENEFITS Life, AD&D, Dependent Life, Out-of-Province/Canada, EHC	Single EHC	Family EHC	EHC Exempt	<ul style="list-style-type: none"> Premiums are subject to PST where applicable Premiums are reviewed annually with adjustments implemented every January 1st, regardless of Coverage Effective Date \$10 per month Admin Fee + GST applies
	\$ _____	\$ _____	\$ _____	
OPTIONAL BENEFITS Dental Care Long Term Disability	Single Dental	Family Dental	LTD	
	\$ _____	\$ _____	\$ _____ / \$100	

9. MANDATORY PRE-AUTHORIZED DEBIT (P.A.D.) PLAN

- The P.A.D. withdrawal will be processed the 1st day of each month.
- ATTACH A VOID CHEQUE along with the initial month's premium deposit accompanying this application.

<< Sign Attached Pre-Authorized Debit (PAD) Agreement >>

10. APPLICATION TO PARTICIPATE IN THE RWAM TRUST
WHEREAS:

- 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");
- 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;
- 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, and other optional group insurance products;
- RWAM Insurance Administrators Inc. ("RWAM") is the authorized agent of the RWAM Trust's Trustees, & 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:

- 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;
- 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.)
- 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.
- 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.
- At all times, to enroll only actively working, eligible permanent employees and their eligible dependents for benefit coverage.
- 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.
- 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.
- To provide RWAM with not less than 30 days advance written notice of its intent to terminate its participation hereunder.

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.

The initial month's premium deposit of \$ _____ (as per Premium Summary) is included with this Application.

Dated at _____ this _____ day of _____ 20_____

Applicant _____
Full Legal/Corporate Name of Group Applicant

Signed X _____
Authorized Signatory for Applicant Print Name & Title

Signed X _____
Agent's Signature Print Name & Agency

Pre-Authorized Debit (PAD) Agreement

GROUP/PAYOR INFORMATION	
Name of Group/Participating Employer _____	
Group Policy Number _____ Division Number _____	
Authorized Plan Administrator _____	
Authorized Plan Administrator's e-mail address for billings _____	
PAYOR'S ACCOUNT INFORMATION	
Type of Account: Current <input type="radio"/> Savings <input type="radio"/> Chequing <input type="radio"/> Other <input type="radio"/> _____	
Account No _____	
Branch Transit No. _____ Financial Institution No. _____	
Name of Financial Institution _____	
Address of Financial Institution _____	
No. & Street	City
Province	Postal Code
<<< ATTACH A VOIDED BLANK CHEQUE TO THIS FORM >>>	

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**, for payment of the above named group/participating employer's group employee benefits plan. I understand this authorization may be cancelled by providing written notice to RWAM at the address indicated below, at 30 days prior and no less than 10 days prior to the next scheduled debit.

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 _____ Date _____

Authorized Signature _____ Date _____

If joint account, additional signature required