# *Benepac®/Benaccount®*
# Employer Application for Group Insurance

Name of Employer

## Employer Information

| Address | Postal Code | Phone | Fax |
|---|---|---|---|
| | | | |

| Web Site Address | Administrative Contact / E-mail Address | Executive Contact / E-mail Address |
|---|---|---|
| | | |

| Nature of Business | Length of Time in Business | Subsidiaries or Affiliates to be Included |
|---|---|---|
| Name of Sponsoring Association (if applicable) | Are all employees covered by WCB? Yes ☐ No ☐ | |

| Is the organization classified as Not-For-Profit? | Are any employees in Canada on a Work Visa/ Permit? | Are there any independent contractors to be included? | Plan Effective Date Requested |
|---|---|---|---|
| Yes ☐ No ☐ | Yes ☐ No ☐ | Yes ☐ No ☐ | |

## Previous Insurance Coverage (if applicable)

| Name(s) of Previous Insurer(s) | Policy Number(s) | Termination Date(s) | Check Benefits in Force with Previous Insurer(s) |
|---|---|---|---|
| | | | ☐ Life ☐ AD&D ☐ Dep Life ☐ STD ☐ CI<br>☐ LTD ☐ EHC ☐ Dental ☐ Other___________ |

## Employee Eligibility / Waiting Period / Participation

### Eligibility

- All employees who work for the employer for the minimum number of hours indicated, are eligible for coverage **(Minimum hours: 20/week)** _________Hours per Week
- Number of employees eligible for this plan ❶ _________Employees

### Waiting Period

- The Waiting Period is the number of continuous months of employment with the employer indicated (Approval required for less than 3 mos) _________Months
- Does the waiting period apply to those employees employed prior to the Plan Effective Date? (check one ✓) ☐ Yes ☐ No

### Participation

- Is this plan Contributory or Non-Contributory? (check one ✓) ☐ Contributory ☐ Non-Contributory
  - Note:
    - Contributory plans are those where the employees are required to pay a portion of the total premium.
    - Non-contributory plans are those where the employer pays 100% of the premium.
- Participation percentage required under this plan _________%
  - Note:
    - 100% of eligible employees must participate for groups with less than 10 employees.
- Number of employees participating in this plan ❷ _________Employees
- Participation percentage for this plan ❷ ÷ ❶ _________%

## Premium Contributions (check benefits insured and indicate percentages paid by Employee and Employer)

| Benefit (check if insured ✓) | Paid by Employee | Paid by Employer | Benefit (check if insured ✓) | Paid by Employee | Paid by Employer |
|---|---|---|---|---|---|
| ☐ Life Insurance | ________% | ________% | ☐ Critical Illness | ________% | ________% |
| ☐ AD/D&D | ________% | ________% | ☐ Extended Health Care | ________% | ________% |
| ☐ Dependent Life Insurance | ________% | ________% | ☐ Dental Care | ________% | ________% |
| ☐ Short Term Disability | ________% | ________% | ☐ Health Spending Account | ________% | 100 % |
| ☐ Long Term Disability | ________% | ________% | ☐ Employee Assistance Program | ________% | ________% |

Note: The Employer must pay at least 50% OF THE TOTAL PREMIUM for this plan — not necessarily 50% of the premium for each benefit. In order for Short Term Disability or Long Term Disability benefits to be received by the Employees on a Non-Taxable basis, all Employees must pay 100% of the premium for these benefits. Ontario Retail Sales Tax – The insurer(s) will remit the applicable sales tax due on behalf of the employer and the employee to the Government of Ontario. Amounts remitted will be in accordance with the current regulations under the Ontario Retail Sales Tax Act, and will apply for the duration of the contract.

## Disabled Employees (as of the Plan Effective Date)

| On the date of this Application, are there any employees on leave or not actively at work due to illness or injury? | Yes | No | |
|---|---|---|---|
| Name of Disabled Employee | Date Last Worked | Expected Date of Return | Nature of Disability |
| | | | |
| | | | |
| | | | |

## Additional Remarks and Underwriting Information

## Employer Participation Agreement and Group Insurance Application

In connection with this Benepac® Employer Application for Group Insurance and the accompanying Schedule of Benefits (collectively, "the application") the Employer:

a) declares that to the best of his knowledge all statements, answers, and representations contained in the application are full, complete and true as of the date signed;

b) understands that coverage will not become effective until the application has been accepted and approved by the insurers underwriting the Benepac® master group contracts issued to BBD Inc., and once accepted, the application will form part of the master group contracts;

c) agrees that a deposit in the amount of $______________________ **payable to BBD** has been submitted with the application and will be applied as a payment towards the first monthly premium once coverage is approved;

d) acknowledges that BBD Inc. is the plan administrator in all matters pertaining to monthly premium billings, premium payments, employee enrollment, group records, employee records, insurer reports, and client service, and agrees to pay any monthly administration fee to BBD Inc. Such fees shall be separate and distinct from any fees, commissions, or allowances which may be received from any insurer for services performed on its behalf;

e) understands that all forms, documents, group records, employee records, reports and other materials used in the administration of this plan, whether in paper or electronic form, are the property of BBD Inc. It is a requirement of each of the insurers underwriting the Benepac® benefits that all such administrative materials be permanently retained by BBD Inc. in a manner and for the time periods prescribed by these insurers;

f) acknowledges that all licensed insurance agents involved in the sale and/or servicing of this group insurance coverage will receive commissions and/or servicing fees from the insurers underwriting the Benepac® benefits;

g) agrees to abide by and be subject to all the terms, conditions, rules, regulations, policy particulars, definitions and other provisions as set out in the Benepac® master group contracts issued to BBD Inc., including any additions or amendments thereto, copies of which are available to view at the offices of BBD Inc. during normal business hours;

h) acknowledges that certain contractual and administrative conditions exist with respect to employer eligibility, employee eligibility, employee participation, waiting periods, effective dates of coverage, evidence of insurability, pre-existing conditions and eligibility for late applicants, and agrees to accept and adhere to these conditions; and

i) agrees to save harmless and indemnify BBD Inc., its shareholders, directors, officers, agents and employees and their respective heirs, executors or assigns, from and against all claims, demands, losses, damages, costs, charges and expenses to which they may be exposed as a direct or indirect, complete or partial consequence of the Employer, any employee of the Employer or any insurance agent acting on behalf of the Employer having supplied inaccurate, incomplete, or false information, or for failing to observe the terms of the Benepac® master group contracts issued to BBD Inc.

| | |
|---|---|
| Authorized Signature of Employer     Date | Witness Signature     Date |
| Name and Title of Authorized Signing Officer | Signature of Licensed Insurance Agent     Date |

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# Health Spending Account - Addendum

| Name of Employer |
|---|
| Effective Date |

## Contributions / Allocation / Rolling Contributions

| | |
|---|---|
| **Coverage**<br>• Benaccount® including fully insured catastrophic coverage<br>• HSA only<br>HSA to cover: | ☐ Yes___ ☐ No<br>☐ Yes___ ☐ No<br>☐ EHC & Dental ☐ EHC Only ☐ Dental Only |
| **Class Description**<br>• Class A: ______________________ | **HSA Contribution Amount**<br>$ __________ per Single Employee per year<br>$ __________ per Couple Employee per year<br>$ __________ per Family Employee per year |
| • Class B: ______________________ | $ __________ per Single Employee per year<br>$ __________ per Couple Employee per year<br>$ __________ per Family Employee per year |
| • Class C: ______________________ | $ __________ per Single Employee per year<br>$ __________ per Couple Employee per year<br>$ __________ per Family Employee per year |
| **Allocation of HSA Dollars**<br>• The HSA Benefit Year is January 1 to December 31. The HSA Contribution Amount will be pro-rated based on the effective date of the plan. Please check the box if you do not want the first year contribution to be pro-rated.<br>• All allocation types require a 2 month security deposit<br>• Please note that BBD® bills monthly | ☐ Do not pro-rate the first year contribution<br>☐ Monthly ☐ Quarterly<br>☐ Semi-Annually ☐ Annually |
| **Grace Period**<br>• The grace period is the time in which a terminated employee must submit claims that were incurred while still covered under the plan. It is also the time period in which covered employees must submit claims from the prior year for reimbursement. **BBD's standard grace period is 90 days**. | ☐ Other: ______________ |
| **Rolling Type**<br>• The unused portion of contributions made in one Benefit Year can be rolled over to the next Benefit Year.<br>• The unpaid portion of a claim incurred in one Benefit Year can be rolled over to the next Benefit Year.<br>• All outstanding contributions / claims will be forfeited at the end of the Benefit Year. | ☐ Contributions<br>☐ Claims<br>☐ None |
| **Additional Information** | |

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# ADMINISTRATIVE SERVICES ONLY – Benaccount HSA

The Client agrees to the terms and conditions as set out in the Master Agreement between BBD Inc. and Green Shield Canada (for Health Spending Accounts).

BBD Inc. is contracted in the administration and adjudication of cash flow healthcare benefits for the employer and its eligible employees and dependents.

The Client recognizes that this agreement is for Administrative Services ONLY and in no way should be considered "insurance". Its purpose is to lower expenses over and above the employer's claims. The costs of all claims plus administrative expenses are the responsibility of the employer. Please note that insured benefits are addressed in other portions of the *Benepac®* Employer Application for Group Insurance.

A "claim" means the amount of money claimed by a participating Practitioner or an Eligible Member for health services covered by the plan (see plan design).

A "contestable claim" means a claim in respect of which the claim procedure or eligibility is subject to determination.

The Client shall pay to BBD in the manner provided in the Benaccount Addendum the amount of all claims paid to the participating Practitioner or eligible employees for health services provided to eligible members plus an administration fee of 9%, exclusive of the Advisor commission. Applicable taxes will also be added.

A security deposit of 2 months of anticipated claims plus taxes is required. This is a security deposit which is held by BBD and not applied to any HSA claims paid. It is fully refunded if the HSA arrangement is discontinued.

Payments are due on the 1st of each month.

Should the employer fail to pay when due any amount payable to BBD Inc. under this agreement, the employer shall pay interest on all the amounts past due at a rate of 1% per month from the date of default until payment. It should also be noted that claim payments may be suspended until such time as late payments and interest are paid to BBD Inc.

| | | | |
|---|---|---|---|
| Authorized Signature of Employer | Date | Witness Signature | Date |
| Name and Title of Authorized Signing Officer | | Signature of Licensed Insurance Agent | Date |

# Pre-Authorized Payment Plan

***Customer Information***

**Company Name:** ______________________________________________

**Company Address:** ______________________________ **City:** ____________________________

**Province:** ____________ **Postal Code:** ______________ **Phone:** __________________________

***Bank Account Information***

**Financial Institution (FI):** ________________________________________

**Branch Address:** ___________________________ **City:** ______________________________

**Province:** ____________ **Postal Code:** ______________ **Phone:** __________________________

**Account Number:** _________________ **Transit Number:** ________ **Bank Number:** __________

***Pre-Authorized Debit Authorization***

These services are for: Personal: ______ Business: _____

BBD is hereby authorized to process a debit, in paper, electronic or other form as follows:

- Variable amount: "$X.xx" with "variable payment amount $X.xx" being stated on a statement available to the company at www.bbd.ca at least 10 calendar days prior to the debit date. To obtain the ID code to access your statement, please contact your Account Manager.
- To be drawn on the above account on the 1st day of each month commencing _______________

I (we) acknowledge that I (we) have read, understand, and agree to all the provisions contained in the terms and conditions of the Pre-Authorized Debit Plan and that I (we) have received a copy of such terms and conditions.

**Authorized Signature** ______________________________________ **Date** ________________

**Authorized Signature** ______________________________________ **Date** ________________

Please return completed form and void cheque to BBD:

**Head Office:**
500 - 2755 Lougheed Highway, Port Coquitlam, BC V3B 5Y9
Tel:(604)464-0313 • Fax:(604)464-7997 • Toll Free:(800)668-2295
www.bbd.ca

**Ontario Office:**
Suite 3 - 55 Rideau Street, Kingston, Ontario K7K 2Z8
Tel:(613)530-2422 • Fax:(613)530-3770 • Toll Free:(888)272-0413
www.bbd.ca

# Pre-Authorized Debit Plan
# Terms and Conditions

***TO BE RETAINED BY PAYOR***

"I (We) acknowledge that this Authorization is provided for the benefit of the Payee and The Royal Bank and is provided in consideration of The Royal Bank agreeing to process debits against my account in accordance with the Rules of the Canadian Payments Association."

"I (We) warrant and guarantee that all persons whose signatures are required to sign on this account have signed this agreement."

"I (We) hereby authorize BBD to draw on the Payor's account number according to the Pre-authorized Debit Authorization."

"This Authorization may be cancelled at any time upon notice by the Payor. I (We) acknowledge that, in order to revoke this Authorization, I (We) must provide notice or revocation to BBD 10 working days prior to the next due date of the Pre-Authorized Debit. I (We) may obtain a sample cancellation form, or more information on my (our) right to cancel a PAD Agreement at my (our) Financial institution or by visiting www.cdnpay.ca."

"I (We) acknowledge that provision and delivery of this Authorization to BBD constitutes delivery by the Payor to The Royal Bank. Any delivery of this Authorization to you constitutes delivery by the Payor."

**"I (We) undertake to inform BBD, in writing, of any change in the account information provided in this Authorization 10 working days prior to the next due date of the Pre-Authorized Debit (PAD)."**

"I (We) acknowledge that The Royal Bank is not required to verify that a PAD has been issued in accordance with the particulars of the Payor's Authorization including, but not limited to, the amount."

"I (We) acknowledge that The Royal Bank is not required to verify that any purpose of payment for which the PAD was issued has been fulfilled by BBD as a condition to honouring a PAD issued or caused to be issued by BBD on the Payor's account."

"Revocation of this Authorization does not terminate any contract for goods or services that exists between the Payor and BBD The Payor's Authorization applies only to the method of payment and does not otherwise have any bearing on the contract for goods or services exchanged."

"I (We) have certain recourse rights if any debit does not comply with this agreement. For example, I (we) have the right to receive reimbursement for any debit that is not authorized or is not consistent with this PAD Agreement. To obtain more information on my (our) recourse rights, or obtain a form for a Reimbursment Claim, I (we) may contact my (our) financial institution or visit www.cdnpay.ca."