



**Group Benefits Master Application**

**Applicant Information**

For internal use only Contract # \_\_\_\_\_

Legal Company Name \_\_\_\_\_

Effective Date Requested

(Month) \_\_\_\_\_ (Day) 01 (Year) \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Contact: \_\_\_\_\_ Title: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

**Applicant's Declaration**

The applicant hereby declares that, to the best of the applicant's knowledge, the statements and answers contained herein are full, complete and true as of the date hereof and expressly agrees and acknowledges that: (1) such statements and answers will form part of the group contract or policy issued by The Benefits Trust and/or its insurance partners; (2) the benefits coverage under the group contract or policy shall become effective in accordance with and subject to the terms of the group contract or policy issued to the applicant; (3) in no case shall coverage become effective until the later of the payment of the initial deposit and approval of this application by The Benefits Trust; and (4) The Benefits Trust will not be liable to the applicant or to any of the applicant's employees or any other persons proposed to be covered under this application until it has been approved. The attached Schedule of Benefits forms part of the application.

The initial deposit of \$ \_\_\_\_\_ is included with this application. Negotiation of the deposit will not, of itself, constitute approval of the application. The deposit will be applied against the first month's contribution statement from The Benefits Trust.

Dated at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_,

by \_\_\_\_\_ (Applicant's signature) \_\_\_\_\_ (Applicant's printed name)

**Broker / Agent Information and Declaration**

Broker / Agent Name: \_\_\_\_\_ Title: \_\_\_\_\_

Broker / Agent Corporate Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

I have advised the applicant: (1) not to terminate any existing coverage until notice has been received in writing that the coverage being applied for is accepted; and (2) no coverage is in existence until this application is approved by The Benefits Trust.

For internal use only  
Agent Number: \_\_\_\_\_

By: \_\_\_\_\_ Date: \_\_\_\_\_

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**Business Information**

Nature of Business: \_\_\_\_\_

Number of Years in Operation: \_\_\_\_\_ Ownership:  Corporation  Partnership  Sole Proprietorship

**Summary Employee Information**

Eligible Employees must be under age 70,  
and work a minimum of 24 hours per week

Number of Employees: \_\_\_\_\_

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**Participation Guidelines**

Please review the Participation Guidelines. The Applicant should initial each guideline to confirm reading and understanding the Guidelines.

Applicant  
Initials

- Minimum 3 employees and minimum \$4,500 in total annual HCSA funding. \_\_\_\_\_
  - Eligible Employees must work a minimum of 24 hours per week. \_\_\_\_\_
  - Waiting period for Full Time Employees is three (3) months unless waived by the Employer upon enrollment. Waiting period does not apply to Eligible Employees currently on payroll as of effective date of benefits plan. \_\_\_\_\_
  - Health Care Spending Account contributions must be fully employer funded in accordance with Revenue Canada guidelines. \_\_\_\_\_
  - Complete applications received at The Benefits Trust on or before the 15<sup>th</sup> of the month will take effect the first of the following month \_\_\_\_\_
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**Coverage Information**

Life Insurance	\$25,000
Accidental Death & Dismemberment	\$100,000
Critical Illness	\$25,000
Excess Medical Stop Loss	\$5,000 per covered person
Out of Country Emergency Medical Care	60 days per trip
Semi-private Hospital Room	\$175 per day, maximum 30 days per year, no maternity coverage
Health Care Spending Account	Amount as determined by plan sponsor

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**SCHEDULE OF BENEFITS**

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**Health Care Spending Account**

**Class**                      **Class Description**

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Benefit Amount:        \_\_\_\_\_ per Benefit Year (12 month period beginning from effective date of coverage)

Benefit Details:        Balance Carry Forward.  
Monthly Billing.  
Benefit amounts for new employees will be pro-rated based on the number of full months worked in the benefit year.  
Changes in benefit amount due to seniority take effect at the start of the benefit year, and will not be pro-rated over the year.

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**Class**                      **Class Description**

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Notes:

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