



10. If this plan is 100% employer paid, 100% participation is required. The employer is required to contribute **at least 50% of the overall premiums** excluding any individual Optional Life premiums. The **employer** will be paying the following percentage for each benefit.

Life/A.D.&D. \_\_\_\_\_ %      Long Term Disability \_\_\_\_\_ %  
 Dependant Life \_\_\_\_\_ %      Extended Health \_\_\_\_\_ %  
 Weekly Indemnity \_\_\_\_\_ %      Dental \_\_\_\_\_ %

Disability benefits (Weekly Indemnity or Long Term Disability) are taxable if the employer pays a portion of the premium for the benefit. Note that if a 70% Weekly Indemnity or Long Term Disability schedule is desired, the plan must be taxable, and therefore the employer must pay a portion of the Weekly Indemnity or Long Term Disability premium. The taxable/non-taxable status of disability benefits cannot vary by employee class.

11. How long has the current employer owned the business? \_\_\_\_\_

12. a) How many employees are on the payroll? \_\_\_\_\_      b) Number of employees to be insured? \_\_\_\_\_  
 c) How many were there this time last year? \_\_\_\_\_

If the number of employees on the payroll does not equal the number of employees to be insured, please explain: \_\_\_\_\_

13. Is the company funded by any outside agency?  Yes  No    If Yes, what is the percentage of funding? \_\_\_\_\_ Please explain: \_\_\_\_\_

14. Are there any employees employed on a contract, consultant, sub-contractor, or seasonal basis applying for coverage under this plan?  Yes  No

15. How many of the employees applying for coverage under this plan are covered by Worker's Compensation? \_\_\_\_\_

16. a) How many individuals included with this application are applying for LTD? \_\_\_\_\_

b) How many of the individuals included in 16 a) are related to one another (i.e., spouse, parent, child, sibling?) \_\_\_\_\_

17. How many employees (including owners) operate business out of their residence? \_\_\_\_\_

18. a) Is any employee currently absent from work due to sickness or injury or has any employee been absent from work due to any one disability for 14 consecutive days in the past 12 months, or, has any employee been absent from work on 6 or more occasions over the past 12 months?  
 If yes, list the employee(s) and indicate date of disability, age and cause of disability.

b) Is any employee absent from work due to layoff? If yes, please provide names, date laid off and expected date for return to work.

19. Describe the classification of employees who will be eligible for benefits.     Class A - All employees  
 or specify    Class A \_\_\_\_\_    Class B \_\_\_\_\_

Note: A minimum of 5 insured lives is required for 2 Classes. A class must contain at least 2 insured lives.

**Termination Age:** All benefits terminate at the Insured Employee's Age 70 or prior retirement, except for Long Term Disability, Optional Life and Optional A.D. & D., which terminate at the Insured Employee's Age 65 or prior retirement.

**20. Waiting Period**

SCHEDULE	CLASS A	CLASS B	WAITING PERIOD TO APPLY TO:
1 Month of continuous employment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Future employees only, or <input type="checkbox"/> Present and Future employees.
3 Months of continuous employment	<input type="checkbox"/>	<input type="checkbox"/>	
6 Months of continuous employment	<input type="checkbox"/>	<input type="checkbox"/>	
12 Months of continuous employment	<input type="checkbox"/>	<input type="checkbox"/>	

New enrolments must be received by Empire Life no later than 31 days after the completion of the waiting period.

### Benefits Applied For

21.  **Basic Life and A.D.& D. (Mandatory)**

SCHEDULE	CLASS A	CLASS B	REDUCTION SCHEDULE	MAXIMUM COVERAGE
1 x Annual Salary *	<input type="checkbox"/>	<input type="checkbox"/>	Coverage Reduces to \$30,000 at age 65.	<input type="checkbox"/> \$500,000 or \$ _____
2 x Annual Salary *	<input type="checkbox"/>	<input type="checkbox"/>		
3 x Annual Salary *	<input type="checkbox"/>	<input type="checkbox"/>		
Flat Amount* of (indicate amount)	\$ _____	\$ _____		

\* The minimum coverage is \$30,000

Employee Accidental Death & Dismemberment Rate,  
all ages (per \$1,000 of insured volume): \$0.06

Combined  
Rate (per \$1,000 of insured volume): \$ \_\_\_\_\_

22.  **Optional Life and A.D.& D.** Units of \$25,000 available to each eligible person

Optional Life Rates (per \$1,000 of insured volume):

Age of Employee	Male		Female	
	Smoker	Non-smoker	Smoker	Non-smoker
<30	\$.12	\$.07	\$.06	\$.04
30-34	.12	.07	.08	.05
35-39	.17	.09	.11	.07
40-44	.27	.15	.19	.11
45-49	.45	.23	.29	.16
50-54	.71	.37	.42	.24
55-59	1.19	.64	.64	.38
60-64	1.79	.97	.96	.58

Employee Optional Accidental Death & Dismemberment Rate, all ages (per \$1,000 of insured volume): \$0.06

23.  **Dependant Life (Mandatory)**

\$10,000 spouse/\$5,000 child

Rate: \$ \_\_\_\_\_

24.  **Weekly Indemnity (optional)**       **No Coverage Desired**

SCHEDULE	<input type="checkbox"/> CLASS A			<input type="checkbox"/> CLASS B		
Percentage of Earnings	<input type="checkbox"/> 60%	<input type="checkbox"/> 66.67%	<input type="checkbox"/> 70%*	<input type="checkbox"/> 60%	<input type="checkbox"/> 66.67%	<input type="checkbox"/> 70%*
Maximum Weekly Benefit	<input type="checkbox"/> E.I. MAX	<input type="checkbox"/> \$600	<input type="checkbox"/> \$900 **	<input type="checkbox"/> E.I. MAX	<input type="checkbox"/> \$600	<input type="checkbox"/> \$900 **
Elimination Period (days) & Maximum Benefit Period (weeks)	<input type="checkbox"/> 0 - 7 - 17		<input type="checkbox"/> 0 - 7 - 26	<input type="checkbox"/> 14 - 14 - 26		
First Day Hospital ***	<input type="checkbox"/> Yes			<input type="checkbox"/> No		

\* Plans with 70% Schedule must be a taxable plan.

\*\* The \$900 Maximum Weekly Benefit is available to groups with 5 or more insured lives for Weekly Indemnity.

\*\*\* First Day Hospital only available to "0-7" Elimination Period Plans.

Rate (per \$10 of insured volume): \$ \_\_\_\_\_

25.  **Long Term Disability (optional)**       **No Coverage Desired**

SCHEDULE	<input type="checkbox"/> CLASS A				<input type="checkbox"/> CLASS B		
Percentage of Earnings	<input type="checkbox"/> 60%	<input type="checkbox"/> 66.67%	<input type="checkbox"/> 70%*	<input type="checkbox"/> Graded Scale**	<input type="checkbox"/> 60%	<input type="checkbox"/> 66.67%	<input type="checkbox"/> 70%* <input type="checkbox"/> Graded Scale**
Maximum Monthly Benefit	<input type="checkbox"/> \$5,500 (maximum) <input type="checkbox"/> Other: \$ _____				<input type="checkbox"/> \$5,500 (maximum) <input type="checkbox"/> Other: \$ _____		
Elimination Period (weeks)	<input type="checkbox"/> 17				<input type="checkbox"/> 26		
Maximum Benefit Period	<input type="checkbox"/> 5 Years				<input type="checkbox"/> to Age 65		

\* Plans with 70% Schedule must be a taxable plan.

\*\* Graded Scale is: 65% of the first \$2,500 of monthly earnings, 50% of the next \$1,667, and 40% on the excess.

Rate (per \$100 of insured volume): \$ \_\_\_\_\_

26.  Extended Health (Optional) Note: If selected, both Classes must be insured.  No Coverage Desired

SCHEDULE	CLASS A	CLASS B
<b>Drugs</b>		
Pay Direct Drug Card Plan		
Plan Type	<input type="checkbox"/> Non-Generic <input type="checkbox"/> Generic	<input type="checkbox"/> Provincial Plus Formulary
Coinsurance	<input type="checkbox"/> 60% <input type="checkbox"/> 75% <input type="checkbox"/> 80% <input type="checkbox"/> 90% <input type="checkbox"/> 100%	<input type="checkbox"/> 60% <input type="checkbox"/> 75% <input type="checkbox"/> 80% <input type="checkbox"/> 90% <input type="checkbox"/> 100%
If PPF is chosen, the coinsurance will be: - 100% Formulary Drugs; - 80% Non-Formulary Drugs		
Deductible	<input type="checkbox"/> \$25/\$50 <input type="checkbox"/> \$50/\$100 or <input type="checkbox"/> \$0 <input type="checkbox"/> \$2 <input type="checkbox"/> \$5 <input type="checkbox"/> \$10 <input type="checkbox"/> Equals Dispensing Fee or <input type="checkbox"/> \$5 Dispensing Fee Maximum <input type="checkbox"/> \$6.50 Dispensing Fee Maximum <input type="checkbox"/> \$7.50 Dispensing Fee Maximum <input type="checkbox"/> \$8 Dispensing Fee Maximum	<input type="checkbox"/> \$25/\$50 <input type="checkbox"/> \$50/\$100 or <input type="checkbox"/> \$0 <input type="checkbox"/> \$2 <input type="checkbox"/> \$5 <input type="checkbox"/> \$10 <input type="checkbox"/> Equals Dispensing Fee or <input type="checkbox"/> \$5 Dispensing Fee Maximum <input type="checkbox"/> \$6.50 Dispensing Fee Maximum <input type="checkbox"/> \$7.50 Dispensing Fee Maximum <input type="checkbox"/> \$8 Dispensing Fee Maximum
Maximum	<input type="checkbox"/> Unlimited <input type="checkbox"/> Maximum of \$2000 Per Certificate, per Benefit Year	<input type="checkbox"/> Unlimited <input type="checkbox"/> Maximum of \$2000 Per Certificate, per Benefit Year
<b>Major Medical</b>		
Coinsurance	<input type="checkbox"/> 60% <input type="checkbox"/> 75% <input type="checkbox"/> 80% <input type="checkbox"/> 90% <input type="checkbox"/> 100%	<input type="checkbox"/> 60% <input type="checkbox"/> 75% <input type="checkbox"/> 80% <input type="checkbox"/> 90% <input type="checkbox"/> 100%
Deductible	Nil	Nil
Vision Care	<input type="checkbox"/> None <input type="checkbox"/> \$100 <input type="checkbox"/> \$150 <input type="checkbox"/> \$200 (Requires a minimum of 5 lives for EHB)	
Vision Care benefit is payable once in any consecutive 2 year period.		
Paramedical Maximum: \$500		
Include First Dollar Top Up where allowed <input type="checkbox"/> Yes <input type="checkbox"/> No (Only available in Saskatchewan, Manitoba and Ontario)		
Private Duty Nursing: \$10,000		
<b>Semi-Private Hospitalization</b> <input type="checkbox"/> Yes <input type="checkbox"/> No \$0/\$0 Deductible, %100 Coinsurance		

Rate: \$ \_\_\_\_\_ Single, \$ \_\_\_\_\_ Family

If your company is primarily based in a Province other than Quebec:

- a) Do you have a physical business location (eg; branch, warehouse, sales office) in the Province of Quebec?  Yes  No
- b) Do you have employees who hold their principle residence in Quebec, but work, in a province other than Quebec?  Yes  No
- If yes to b) do you wish to provide such employees with Drug coverage which complies with Quebec Universal Drug legislation?  Yes  No

27.  Dental (Optional) Note: If selected, both Classes must be insured.  No Coverage Desired

SCHEDULE	CLASS A	CLASS B
<b>Basic Restorative and Periodontics-Endodontics</b>		
Coinsurance	<input type="checkbox"/> 60% <input type="checkbox"/> 80% <input type="checkbox"/> 90% <input type="checkbox"/> 100%	<input type="checkbox"/> 60% <input type="checkbox"/> 80% <input type="checkbox"/> 90% <input type="checkbox"/> 100%
Deductible	<input type="checkbox"/> \$0/\$0 <input type="checkbox"/> \$25/\$50 <input type="checkbox"/> \$50/\$100	<input type="checkbox"/> \$0/\$0 <input type="checkbox"/> \$25/\$50 <input type="checkbox"/> \$50/\$100
Maximum	<input type="checkbox"/> \$750 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 Per Benefit Period	<input type="checkbox"/> \$750 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 Per Benefit Period
Recall	6 months	6 months
<b>Major Restorative</b>	<input type="checkbox"/> Include <input type="checkbox"/> Do not include	
Coinsurance	50% \$1,000 Benefit Year Maximum	
Deductible	Selected Dental Deductible Applied Requires a minimum of 5 insured lives for Dental	
<b>Orthodontics</b>	<input type="checkbox"/> Include <input type="checkbox"/> Do not include	
Coinsurance	50%	
Deductible:	\$0/\$0	
Maximum	\$1,500 Lifetime Maximum Requires a minimum of 10 insured lives for Dental	
Fee Guide	<input type="checkbox"/> Based on Employee's Province of Residence <input type="checkbox"/> Based on Employer's Province of Residence	

Rate: \$ \_\_\_\_\_ Single, \$ \_\_\_\_\_ Family

FOR GROUPS OF 2.4 LIVES, A MINIMUM OF 2 OPTIONAL BENEFITS MUST BE ELECTED.

## 28. Pre-authorized Payment Plan

### How does the plan work?

You continue to receive your monthly statement as usual, detailing all the changes.

The total amount due is deducted automatically from your bank account each month.

The automatic withdrawal is processed on the 10th day of each month (or the next business day) for the premium due for the billing period for that month.

### When does the plan start?

You will be notified on the billing statement when your account has been switched to the Pre-Authorized Payment Plan. Please continue to pay your monthly statement in the usual manner until you receive this notification. If you should make any changes in your banking arrangements or need to notify us of any changes in your banking procedures, please call 1-800-267-0215.

### Terms & Conditions

This Pre-Authorized Payment Plan is for the convenience of our client. There are no charges to enroll in the plan.

The client certifies that the information provided in the authorization is correct and that the client will notify Empire Life in the event of any changes.

The client certifies that his/her bank account is in good standing with sufficient funds to cover pre-authorized payments as they come due.

All pre-authorized payments will be drawn on Canadian financial institutions only and will be withdrawn in Canadian Funds.

### Cancellation

This agreement can be terminated, upon written notification, at any time, by either the client or Empire Life. Upon termination, any amount due shall be paid directly to Empire Life.

Cancellation of pre-authorization payment does not constitute cancellation of service by Empire Life and the client shall be liable for any past, present or future amounts owing.

### AUTHORIZATION AGREEMENT

Yes, I/we hereby authorize Empire Life to withdraw the amount due on my/our billing statement from my/our financial institution on the 10<sup>th</sup> day of each month (or the next business day).

Please attach a void cheque.



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 that (1) such statements and answers shall constitute the Application for and form part of the Contract, and (2) the insurance shall become effective in accordance with and subject to the Policy to be issued to the Applicant but in no case shall it become effective until this Application has been approved by The Empire Life Insurance Company (hereinafter called the Company).

"The Applicant confirms that it has obtained individual plan member consent to the collection, use and disclosure of member personal information (including personal information about member dependant(s)) required for plan enrollment and ongoing administration of the plan."

In the case of apparent errors and omissions discovered by the Company in this Application, the Company is hereby authorized to amend this Application by noting the change(s) in the section entitled "CORRECTIONS/AMENDMENTS" and acceptance of the Policy accompanied by a copy of this Application so amended, shall constitute a ratification of such changes or amendments.

Cost Plus Addendum is included for EHB, if EHB is insured under this Policy.

Cost Plus Addendum is included for Dental, if Dental is insured under this Policy.

An initial Premium Deposit of \$ \_\_\_\_\_ is included with this Application. Negotiation of the cheque will not, of itself, constitute approval of the Application.

Dated at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_.  
(Month) (Year)

for \_\_\_\_\_  
Applicant (Full Company Name)

by \_\_\_\_\_  
(Signature and Title of Authorized Official)

Witness \_\_\_\_\_

**Producer Comments:**

### Producer's Information

**Note:** The Producer's Information section must be completed in full by the producer before application will be accepted.

Producer's Name \_\_\_\_\_

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

Address \_\_\_\_\_

City/Province/Postal Code \_\_\_\_\_

Telephone ( ) \_\_\_\_\_

Internet E-Mail Address \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

Resource Centre \_\_\_\_\_

Group Office \_\_\_\_\_

Empire Life Producer Code \_\_\_\_\_

### Producer's Commitment

**I have advised the applicant not to terminate any existing coverage until notice has been received that the coverage being applied for is accepted.**

**To the best of my knowledge and belief all statements in this Application are true and complete. I have read and understand the form.**

By: \_\_\_\_\_ Date: \_\_\_\_\_  
(Producer's Signature)

### PLEASE ENSURE THAT:

- 1) All required sections of the application have been completed and it has been signed and dated prior to the requested effective date.
- 2) Enrolment Forms and, where necessary, Group Non-Medical Declarations have been filled out and enclosed for all full time employees and that additional evidence requirements have been communicated to employees.
- 3) A copy of the **current** billing showing in-force volumes by employee if present coverage in-force.
- 4) A cheque for one month's premium payable to The Empire Life Insurance Company has been enclosed with the application.
- 5) A complete copy of the quotation for this group has been enclosed.

