VERSION DATE: JANUARY 2018

20PLUS
APPLICATION FOR GROUP INSURANCE

Policies are issued by:

The Empire Life Insurance Company

Empire Life
259 King Street East
Kingston ON K7L 3A8

www.empire.ca

G-0001-EN-01/18

APPLICATION FOR GROUP INSURANCE

Reset Form

1 Policyowner/Applicant (legal name as indicated on employee T4):

What name should appear on your Employee Booklets and Benefit Cards? ◯ Name above ◯ Other:

2

Address (number, street):	City	Province	Postal code

3

Plan Administrator (Name):	Telephone	Fax	Email address
Plan Administrator (Name):	Telephone	Fax	Email address
Plan Administrator (Name):	Telephone	Fax	Email address

4 Type of Business (Goods or Services Provided):

5 Ownership (Check one): ◯ Sole Proprietorship ◯ Partnership ◯ Corporation ◯ Limited Liability Partnership
Name(s) of Owner(s), if Sole Proprietorship, Partnership or Limited Liability Partnership:

6 **Affiliated Companies** to be included (Print exact legal name(s) as per T4 documents) ◯ Yes ◯ No
If more than 2 affiliated companies, complete and attach a list of affiliated companies.

Affiliated company #1 Are separate billing statements required? ◯ Yes ◯ No (If Yes, please complete Section 13)

Division #:	Name to appear on booklet and benefit cards:		
Name:	Legal name:		
Address (number, street):	City	Province	Postal code

Plan Administrator (name):

Telephone	Fax	Email address

Business relationship to Policyowner: ◯ Common Ownership ◯ Subsidiary ◯ Other:

Nature of Business:

Number of Employees in affiliated company #1:

Affiliated company #2 Are separate billing statements required? ◯ Yes ◯ No (If Yes, please complete Section 13)

Division #: Name to appear on booklet and benefit cards:

Name:	Legal name:		
Address (number, street):	City	Province	Postal code

Plan Administrator (name):

Telephone	Fax	Email address

Business relationship to Policyowner: ◯ Common Ownership ◯ Subsidiary ◯ Other:

Nature of Business:

Number of Employees in affiliated company #2:

7 **REQUESTED EFFECTIVE DATE** for all coverage is 12:01 a.m. **EST** on
(day) (month), (year).

8 **FIRST YEAR RENEWAL DURATION:** 15 months

9 Present Coverage

To avoid a period without coverage, do not terminate any existing coverage until notice has been given in writing that the coverage being applied for is approved by The Empire Life Insurance Company (the effective date will normally be the first day of the month following approval).

When applying for a Group Benefit Plan with The Empire Life Insurance Company (Empire Life), the Applicant must obtain individual plan member consent for the collection, use and disclosure of plan member personal information (including personal information about plan member dependant(s)) required for plan enrolment and ongoing administration of the plan.

Will the insurance applied for replace similar insurance? ◯ Yes ◯ No

If Yes, complete this section, and **provide a full copy of your most recent billing statement**.

Benefit	Name of Current Carrier	Issue Date	Proposed Termination Date
◯ Life			
◯ A.D.&D.			
◯ Optional Life			
◯ Dependant Life			
◯ Optional AD&D			
◯ Critical Illness			
◯ Weekly Indemnity			
◯ Long Term Disability			
◯ Extended Health			
◯ Dental Benefit			

Healthcare Pooling

Is your current coverage eligible for Extended Healthcare Policy Protection Plan (EP3) pooling?
◯ Yes ◯ No – **If yes, please provide your most current Inter-Company EP3 Statement**

10 Participation

Participation under this Plan is ◯ Mandatory* ◯ Non-mandatory**

* If participation is Mandatory, 100% of all eligible employees who are actively at work must be insured for all benefits for which they are eligible. If the Plan is 100% Employer paid, it is a Mandatory Plan.

** If participation is Non-mandatory, an eligible employee is allowed to refuse all coverage, subject to the minimum participation requirements of the Policy. An employee refusing coverage under the Plan must refuse all coverage. Refusal of some, but not all, coverage is not permitted.

If the Plan includes Extended Health and/or Dental Benefits, an eligible employee may waive coverage for these benefits if insured for similar coverage under their spouse's plan. Such waivers will not affect the participation level.

11 Eligible Employees

What is the minimum number of hours per week that Employees must work to be considered eligible? _____ hours.
Note that the **lowest allowable figure is 20 hours per week** and that the employees must be active, reside in Canada, with provincial health coverage, and be employed on a permanent basis in Canada.

Total Number of Employees to be insured as of the Policy Effective Date*:

Total Number of Employees on payroll as of the Policy Effective Date*:

***Are any employees excluded from coverage? Explain why:**

Additional Coverage is being extended to:
◯ Retirees ◯ Early Retirees (age _____ to 65) ◯ Part-time Employees (_____ hours per week)

12 Definition of Salary

Select all that apply: ◯ Base Salary ◯ Commissions* ◯ Bonus**
◯ Dividends included in Owners and /or Executives definition of earnings (3 year average). Separate class required.
*Dividends paid through a holding company are not eligible under the definition of salary.

If commissions/bonuses are to be included, salary to be based on:
◯ Previous calendar year T-4 or ◯ the average of the previous 2 years T-4's

** If bonus to be included – advise: Frequency of Bonus: ◯ Annual ◯ Monthly ◯ Other:

**Explain how Bonus is determined or calculated:

13 Divisions and Class Structure

Division #	Class	Class Description

If additional Divisions/Classes are required, complete, sign and attach separate listing titled "Division and Class Structure Appendix"

14 Waiting Period

Division:					
Class:					
Schedule					
3 Months of continuous employment:					
6 Months of continuous employment:					
Other: (specify)					

Waiting Period to Apply to: ◯ Employees currently within a waiting period and Future Employees ◯ Future Employees Only

15 Policyowner Premium Contributions

(indicate the percentage of the cost to be paid by **the Policyowner** for each benefit)

Division:					
Class:					
a) Life					
b) AD&D					
c) Dependant Life					
d) Critical Illness – Employee					
e) Critical Illness – Spouse					
f) Critical Illness – Dependant					
g) Weekly Indemnity*					
h) Long Term Disability*					
i) Extended Health					
j) Dental					

* Disability benefits (Weekly Indemnity or Long Term Disability) are taxable if the employer pays any portion of the premium for the benefit.

Note that if a Weekly Indemnity or Long Term Disability Benefit of 67% of Earnings or greater is desired, the plan must be taxable. The taxable/non-taxable status of disability benefits may vary by employee class.

16 General Information

Have any lay-offs occurred in the past five years? ◯ Yes ◯ No
If Yes indicate the class and number of eligible employees who were affected:

Is a lay-off provision* required in this policy? ◯ Yes ◯ No – If yes, number of months _____ *(not to exceed 6 months)*
Is a leave of absence* provision required? ◯ Yes ◯ No – If yes, number of months _____ *(not to exceed 6 months)*
* The lay-off and leave of absence provision excludes Weekly Indemnity and Long Term Disability benefits.

Are all employees covered by provincial workplace safety legislation (e.g. WSIB, WCB/CSST, WorkSafe BC)
◯ Yes ◯ No – If "No", Industry exempt?
◯ Yes ◯ No – If "No", indicate those employees who are not covered:

(i) Are benefits **Union** negotiated? ◯ Yes* ◯ No
* If "Yes", include a complete copy of the Union Collective Agreement and answer question (ii) below.
(ii) Are all Classes **Union** negotiated? ◯ Yes ◯ No**
** If **"No"**, indicate which Classes are **Union** negotiated:
(iii) Date of last **Union** negotiation? _____

Are any proposed employees/insureds employed on a contract or consultant basis, as members of the Board of Directors, Shareholders, or Sub-Contractors of the Policyowner? ◯ Yes ◯ No – If "Yes", indicate those employees/insureds below:
Note: additional details may be required to determine eligibility under the terms of the Policy.

Name (last, first)	Work primarily for Policyowner?	How compensated?	
		T-4/RL-1	Fee for Service
	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No

17 Employees Not Actively at Work

1. a) Are there any Employees currently insured with the present carrier, that are **not** actively at work for reasons other than vacation? ◯ Yes ◯ No

b) List ALL individuals who are currently absent from work due to the following: (not including vacation)

Reason Code:
(i) Maternity/Paternity Leave
(ii) Layoff
(iii) Leave of Absence
(iv) Workplace safety benefits (e.g. WSIB/WCB/CSST)
(v) Short (WI) or Long Term Disability (LTD) with another carrier
(vi) Employment Insurance Sickness Benefits (EI)
(vii) Reduced hours/modified duties/gradual return to work program
(viii) Other (please explain):

Name (last/first)	Date of birth (dd/mm/yyyy)	Class & occupation	Reason code for absence	Date of leave or disability	Expected date of return to work

17	**c) For any individuals listed in 1.b) with Reason Code (iv) to (viii) inclusive - provide details of claim type(s) for each individual**		
Name (last/first)	Claim Type	Applied for:	Approved
	○ Workplace safety benefits ○ WI ○ EI ○ LTD ○ Life Waiver of Premium	○ Yes ○ No ○ Yes ○ No ○ Yes ○ No	○ Yes ○ No ○ Yes ○ No ○ Yes ○ No
	○ Workplace safety benefits ○ WI ○ EI ○ LTD ○ Life Waiver of Premium	○ Yes ○ No ○ Yes ○ No ○ Yes ○ No	○ Yes ○ No ○ Yes ○ No ○ Yes ○ No
	○ Workplace safety benefits ○ WI ○ EI ○ LTD ○ Life Waiver of Premium	○ Yes ○ No ○ Yes ○ No ○ Yes ○ No	○ Yes ○ No ○ Yes ○ No ○ Yes ○ No
	○ Workplace safety benefits ○ WI ○ EI ○ LTD ○ Life Waiver of Premium	○ Yes ○ No ○ Yes ○ No ○ Yes ○ No	○ Yes ○ No ○ Yes ○ No ○ Yes ○ No
	○ Workplace safety benefits ○ WI ○ EI ○ LTD ○ Life Waiver of Premium	○ Yes ○ No ○ Yes ○ No ○ Yes ○ No	○ Yes ○ No ○ Yes ○ No ○ Yes ○ No

18 Provincial Employees

a) Do any employees have their principal residence in Quebec? ○ Yes ○ No

b) Do you have a physical business location (e.g. branch, warehouse, sales office) in the province of Quebec? ○ Yes ○ No

c) If you do not have a physical business location in Quebec, do you wish to provide your Quebec residents with drug coverage that complies with the Quebec Universal Drug legislation? ○ Yes ○ No

19 Unit Premium Rates

The actual premium rates at inception of the Plan will be determined in accordance with the employee data as at the Effective Date of the Policy. *Note: Place "All" in the Class row if Rates are the same for all Classes.*

Division:	______	______	______	______	______
Class:	______	______	______	______	______
Fully Insured Rates					
a) Employee Life (per $1,000 of insurance)	______	______	______	______	______
b) Employee A.D.& D. (per $1,000 of insurance)	______	______	______	______	______
c) Dependant Life	______	______	______	______	______
d) Critical Illness – Employee (per $1,000 of insurance)	______	______	______	______	______
e) Critical Illness – Spouse (per $1,000 of insurance)	______	______	______	______	______
f) Critical Illness – Dependant (per $1,000 of insurance)	______	______	______	______	______
g) Weekly Indemnity (per $10 of insurance)	______	______	______	______	______
h) Long Term Disability (per $100 of insurance)	______	______	______	______	______
i) Extended Health Benefit					
Single	______	______	______	______	______
Family	______	______	______	______	______
Monoparental	______	______	______	______	______
Couple	______	______	______	______	______
j) Dental Benefit					
Single	______	______	______	______	______
Family	______	______	______	______	______
Monoparental	______	______	______	______	______
Couple	______	______	______	______	______

19 **ASO Deposit Rates**

k) Extended Health Benefit (indicate EHB fully insured rates above)

Single					
Family					
Monoparental					
Couple					

l) Dental Benefit

Single					
Family					
Monoparental					
Couple					

Optional Life (per $1,000 of insurance)

m)

Age Band	Smoker Male	Smoker Female	Non-Smoker Male	Non-Smoker Female
Under 30	0.12	0.06	0.07	0.04
30-34	0.12	0.08	0.07	0.05
35-39	0.17	0.11	0.09	0.07
40-44	0.27	0.19	0.15	0.11
45-49	0.45	0.29	0.23	0.16
50-54	0.71	0.42	0.37	0.24
55-59	1.19	0.64	0.64	0.38
60-64	1.79	0.96	0.97	0.58
65-69	2.59	1.45	1.44	0.84

Optional A.D.&D. Rate (per $1,000 of insurance) is equal to Employee A.D.&D. rate entered in section b) above.

Premium Rates for Spousal Optional Life and A D&D equal the Employee Optional Life Premium Rates, if Spousal Optional Life (and A.D.&D.) is insured under the Policy. For Optional employee, Optional spouse, and Optional dependant CI, please see appendix.

SCHEDULE OF BENEFITS

20 **Employee Life Benefit** ◯ Yes ◯ No **Employee A.D.&D. Benefit** ◯ Yes ◯ No

Note "All" in the Class row if coverage applies to all classes **and** coverage details are the same for all classes.

Division:					
Class:					
a) Life Schedule*					
b) Life Maximum Amount					
c) AD&D Schedule*					
d) AD&D Maximum Amount					
e) Reduction Schedule at age 65					
f) Reduction Schedule at age 70 (if terminates at age 75 or later)					
g) Termination Age					

No Evidence Limit $ _____. Any Employee Life and/or AD&D Benefit in excess of the No Evidence Limit will be granted only subject to evidence of insurability satisfactory to Empire Life for plan enrolees under age 65. Age 65 and over, any Employee Life and/or AD&D Benefit in excess of one half of the No Evidence Limit will be granted only subject to evidence of insurability satisfactory to Empire Life.

* If the Life and/or AD&D schedule is a multiple of salary, the minimum coverage is $20,000 or $10,000 when combined with $10,000 Traditional or Enhanced Critical Illness.

21 Employee Optional Life Benefit ◯ Yes ◯ No Employee Optional A.D.&D. Benefit ◯ Yes ◯ No

(Optional AD&D only available if Employee AD&D and Employee Optional Life selected)

Note "All" in the Class row if coverage applies to all classes and coverage details are the same for all classes.

Division:					
Class:					
a) Optional Life Schedule					
b) Optional Life Maximum Amount					
c) Optional AD&D Schedule					
d) Optional AD&D Maximum Amount					
e) Reduction Schedule (none or 50% at age 65)					
f) Termination Age (65 or 70)					

EVIDENCE OF INSURABILITY IS REQUIRED FOR ALL AMOUNTS OF EMPLOYEE OPTIONAL LIFE BENEFITS.
The minimum coverage is $10,000.

22 Dependant Life Benefit ◯ Yes ◯ No

Note "All" in the Class row if coverage applies to all classes **and** coverage details are the same for all classes.

Division:					
Class:					
a) Spouse Amount					
b) Dependant Child Amount					
c) Termination Age*					

* Termination age is based on the age of the employee. The Termination age for insured dependent children is the attainment of age 22, 26 if full-time student at an accredited educational institution.

23 Spousal Optional Life Benefit (Only available if Employee Optional Life selected) ◯ Yes ◯ No
Spousal Optional A.D.&D. Benefit (Only available if Spousal Optional Life selected) ◯ Yes ◯ No

Note "All" in the Class row if coverage applies to all classes **and** coverage details are the same for all classes.

Division:					
Class:					
a) Spousal Optional Life Schedule					
b) Spousal Optional Life Maximum Amount					
c) Spousal Optional AD&D Schedule					
d) Spousal Optional AD&D Maximum Amount					
e) Reduction Schedule (none or 50% at age 65)					
f) Termination Age (65 or 70)					

EVIDENCE OF INSURABILITY IS REQUIRED FOR ALL AMOUNTS OF SPOUSAL OPTIONAL LIFE BENEFITS.

24 Group Critical Illness Insurance

Available for groups with a minimum of 3 Critical Illness lives. Plan design can vary by class.

Please select from the options below, where applicable:

Employee Critical Illness ○ No Coverage

		Class: _____ _____ _____ _____ _____
Type of coverage	Choose from options below for each class: Vital Assist CI – Core Coverage (4 conditions) (VACI) Traditional CI – Complete Coverage (31 conditions) (TCI) Enhanced CI – Multiple Event Coverage (31 conditions, 6 partial conditions) (ECI)	_____ _____ _____ _____ _____
Benefit Amounts	Choose from options below for each class: Vital Assist CI – $10,000, $20,000, $30,000 Traditional or Enhanced ($10,000 - $250,000 in $1,000 increments)	$_____ $_____ $_____ $_____ $_____
Termination Age	Vital Assist CI – 65 Traditional /Enhanced CI - 70	
Reduction Schedule	Vital Assist CI – None Traditional and Enhanced – 50% at age 65	
No Evidence Limit	Vital Assist CI – Not applicable Traditional/Enhanced CI $ _____	
Waiver of Premium	Vital Assist CI – Not included Traditional/ Enhanced CI – Included	
Health Concierge Service	Included for employee and all eligible dependants	
Pre-existing Condition Exclusion Period (Employee choice also applies to Spouse and Dependant coverage)	Vital Assist CI – Not Applicable Traditional/Enhanced CI ○ 24/24 (default) OR ○ 12/12 (Option for Groups of 50 or more CI Lives) OR ○ 0/0 (Option for Groups of 200+ CI Lives)	

Spousal Critical Illness ○ No Coverage

(Only available if Employee CI selected – and must select the same type of coverage within each class)

		Class: _____ _____ _____ _____ _____
Type of coverage	Choose from options below for each class: Traditional CI – Complete Coverage (31 conditions) (TCI) Enhanced CI – Multiple Event Coverage (31 conditions, 6 partial conditions) (ECI)	_____ _____ _____ _____ _____
Benefit Amount (Spouse coverage cannot exceed Employee coverage)	Choose from options below for each class: $10,000 - $25,000 in $1,000 increments	$_____ $_____ $_____ $_____ $_____
Termination Age	Employee age 70	
Reduction Schedule	50%, employee age 65	
No Evidence Limit	No medical underwriting required	
Waiver of Premium	Included	

24 ◯ Dependant Critical Illness ◯ No Coverage (only available if Employee CI selected)

	Class:	_____ _____ _____ _____ _____
Type of coverage	**Choose from options below for each class:** Complete Traditional CI Coverage (15 conditions) (TCI) Partial/multiple/cancer recurrence benefits not available for dependent children	_____ _____ _____ _____ _____
Benefit Amount	$5,000 per child	
Termination Age	The termination age for insured dependant children is the attainment of age 22, 26 if a full-time student at an accredited educational institution, and employee age 70, or prior retirement.	
Reduction Schedule	Not included	
Waiver of Premium	Included	

25 Optional Group Critical Illness Insurance (Must have Employee CI to select Optional CI)

◯ Employee Optional Critical Illness ◯ No Coverage

	Class:	_____ _____ _____ _____ _____
Type of coverage	Choose from options below for each class: ◯ Traditional Critical Illness (TCI) (Complete Coverage – 31 conditions) OR ◯ Enhanced Critical Illness (ECI) (Multiple Event Coverage – 31 conditions/6 partial conditions) Benefit offered in Units of $1,000 subject to maximum chosen below	_____ _____ _____ _____ _____
Maximum Benefit	Choose maximum benefit per class: $10,000 minimum - $250,000 maximum	$_____ $_____ $_____ $_____ $_____
Termination Age	65	
No Evidence Limit	Full medical underwriting required	
Waiver of Premium	Included	

◯ Spousal Optional Critical Illness ◯ No Coverage (Only available if Optional Employee CI selected)

	Class:	_____ _____ _____ _____ _____
Type of coverage	Choose from options below for each class: ◯ Traditional Critical Illness (TCI) (Complete Coverage – 31 conditions) OR ◯ Enhanced Critical Illness (ECI) (Multiple Event Coverage – 31 conditions/6 partial conditions) Benefit offered in Units of $1,000	_____ _____ _____ _____ _____
Maximum Benefit	Choose maximum benefit per class: $10,000 minimum - $250,000 maximum	$_____ $_____ $_____ $_____ $_____
Termination Age	Employee age 65	
No Evidence Limit	Full medical underwriting required	
Waiver of Premium	Included	

25 ◯ Dependant Optional Critical Illness ◯ No Coverage (Only available if Optional Employee CI selected)

	Class:	_____ _____ _____ _____ _____
Type of coverage	Traditional Critical Illness (TCI) (Complete Traditional CI Coverage – 15 conditions)* * Partial/multiple/cancer recurrence benefits not available for dependent children Benefit offered in Units of $1,000 subject to maximum chosen below	
Maximum Benefit	Choose maximum benefit per class: $5,000 minimum – $25,000 maximum	$_____ $_____ $_____ $_____ $_____
Termination Age	Employee age 65	
No Evidence Limit	No medical underwriting required. Pre-existing conditions exclusion applies.	
Waiver of Premium	Included	

26 Weekly Indemnity Benefit ◯ Yes ◯ No

Note "All" in the Class row if coverage applies to all classes **and** coverage details are the same for all classes.

Division:	_____	_____	_____	_____	_____
Class:	_____	_____	_____	_____	_____
a) Percentage of Weekly Earnings*	_____	_____	_____	_____	_____
b) Maximum Weekly Benefit	_____	_____	_____	_____	_____
c) Elimination Period (days) – INJURY	_____	_____	_____	_____	_____
d) Elimination Period (days) – SICKNESS	_____	_____	_____	_____	_____
e) Maximum Benefit Period (weeks)	_____	_____	_____	_____	_____
f) Include 1st Day Hospital/Outpatient Surgery (Y or N)	_____	_____	_____	_____	_____
g) Termination Age (up to age 70)	_____	_____	_____	_____	_____

No Evidence Limit $ _____.

Are these benefits to be registered under the Employment Insurance (EI) Premium Reduction Plan or any Government Sponsored Plan?
◯ Yes ◯ No

* If percentage of Weekly Earnings noted in a) above is 67% or greater, and/or the Employer pays any portion of the WI premium, then the benefit will be issued as a taxable benefit. Can vary by class.

27 Long Term Disability Benefit ◯ Yes ◯ No

Note "All" in the Class row if coverage applies to all classes **and** coverage details are the same for all classes.

Division:	_____	_____	_____	_____	_____
Class:	_____	_____	_____	_____	_____
a) Percentage of Monthly Earnings* or	_____	_____	_____	_____	_____
b) Graded Schedule**	_____	_____	_____	_____	_____
c) Maximum Monthly Benefit	_____	_____	_____	_____	_____
d) Elimination Period (days) – INJURY	_____	_____	_____	_____	_____
e) Elimination Period (days) – SICKNESS	_____	_____	_____	_____	_____
f) Maximum Benefit Period (2 year, 5 year, age 65 less elimination period)	_____	_____	_____	_____	_____
g) Own Occupation Period (years)	_____	_____	_____	_____	_____
h) Survivor Benefits (none, 3 months, 6 months)	_____	_____	_____	_____	_____
i) Cost of Living Allowance (COLA) (No or %)	_____	_____	_____	_____	_____

Termination Age is 65

27

* If percentage of Monthly Earnings noted in a) above is 67% or greater, and/or the Employer pays any portion of the LTD premium, then the benefit will be issued as a taxable benefit. Can vary by class.

** Graded schedule (if applicable): _____% of the first $ _____; _____ % of the next $ _____, and _____% of the excess.

No Evidence Limit $ _____

CPP/QPP integration will be Primary.
The all source maximum benefit is 85% of pre-disability take home pay when benefits are non-taxable, or 85% of the pre-disability Monthly Earnings when the benefits are Taxable.

28

Extended Health Benefit ◯ Yes ◯ No

Note "All" in the Class row if coverage applies to all classes **and** coverage details are the same for all classes.

Division: _____ _____ _____ _____ _____

Class: _____ _____ _____ _____ _____

Benefit Period (must be the same for all classes)	◯ Calendar Year ◯ Benefit Year	
Termination Age*	60 to 85 years	_____ _____ _____ _____ _____

*The termination age for insured dependant children is the attainment of age 22, 26 if full-time student at an accredited educational institution.

Survivor Benefits	◯ None ◯ 1 year ◯ 2 years
Healthcare Pooling (per insured, per benefit year)	Threshold must be the same for both classes **All EHB Benefits, except Emergency Travel Assistance Program** ◯ $10,000 (default) ◯ $15,000 ◯ $20,000 ◯ $25,000 **DRUGS only** ◯ $7,500* *Must also select Mandatory Generic Drug Plan and Empire Life R&C Dispensing Fee

Empire Life participates in the drug pooling agreement offered by the Canadian Drug Insurance Pooling Corporation (CDIPC). The CDIPC requires fully insured drug benefit plans to include pooling protection, called an EP3. Some claims may be ineligible for EP3 and, if so, Empire Life will provide a Large Amount Pooling (LAP) arrangement.

Drug Plan

Includes Pay Direct Drug Card, Prior Authorization, and Specialty Drug Plan.

Extended Health Benefits will be administered in accordance with the requirements of applicable provincial prescription drug legislation, and will meet any applicable minimum coverage standard.

When selecting drug coverage choose the Standard Drug Plan or Actively Managed Drug Solutions - Maintenance Drugs (excludes Quebec)

Drug Benefit Type	◯ **Standard Drug Plan** ◯ **Actively Managed Drug Solutions - Maintenance Drugs**	
	Division:	_____ _____ _____ _____ _____
Standard Drug Plan	**Class:**	_____ _____ _____ _____ _____
Drug Plan Type		
Prescription By Law, OR	Brand (RXA), Generic (RXAG), Mandatory Generic Substitution (RXMG), Provincial Formulary (RXO)	_____ _____ _____ _____ _____
Prescribed (Over the counter medication included)	Brand Name (RXB), Generic (RXBG)	_____ _____ _____ _____ _____
Coinsurance		
Flat, or	50% to 100% in 5% increments	_____ _____ _____ _____ _____
Two Tier	50% to 100% in 5% increments	_____ _____ _____ _____ _____
	Generic/Brand Name, or Provincial Formulary/Non Provincial Formulary	_____ _____ _____ _____ _____
Graded	_____% of first $ _____, _____%	_____ _____ _____ _____ _____

28	**Deductible**		**CLASS**
	Annual Single/Family, or	◯ $0/$0, ◯ $25/$50, ◯ $50/$100, or ◯ Other (indicate amount)	_____ _____ _____ _____ _____
	Per Prescription, or	◯ Dispensing Fee, or ◯ $0 to $20 in $0.50 increments (indicate amount)	_____ _____ _____ _____ _____
	Dispensing Fee Maximum *not applicable to employees and/or eligible dependants residing in Quebec	◯ $0 to $20 in $0.50 increments (indicate amount), or ◯ Empire Life Reasonable & Customary (Default)*	_____ _____ _____ _____ _____
	Maximum		
	All Drugs, except Specialty Classes list below		
	All Plan Types	Unlimited, or $500 to $10,000 in $500 increments. Indicate per Certificate (C), or per Insured (I)	_____ _____ _____ _____ _____
	Specialty Classes – (if selected will follow drug coinsurance and drug deductible)		
	Smoking Cessation, Lifetime Maximum	Yes/No $100 to $700 in $50 increments	_____ _____ _____ _____ _____
	Sexual Dysfunction, Annual Maximum	Yes/No $0, $500, $750, $1,000, $1,500	_____ _____ _____ _____ _____
	Fertility Drugs, Lifetime Maximum	Yes/No $0, $2,500, $4,000, Other	_____ _____ _____ _____ _____
	Actively Managed Drug Solutions – Maintenance Drugs (excludes Quebec)		
	Actively Managed Plan Type Your Specialty Drug program will align with the program you choose.	◯ **Preferred Choice** To receive the higher level of reimbursement for maintenance drugs, they must be purchased through the Express Scripts Canada (ESC) Pharmacy. If purchased through a retail pharmacy, they will still be covered, but reimbursed 20% less than if purchased through the ESC Pharmacy. Eligible drugs not available through the ESC Pharmacy, will be reimbursed at the higher level. Your Specialty Drug Program will remain Preferred Choice. ◯ **Exclusive Choice** For maintenance drugs to be covered by the drug plan, they must be purchased at the ESC Pharmacy. All other drugs, including maintenance drugs not available through the ESC Pharmacy, can be purchased through a retail pharmacy and they will be covered under the plan. Your Specialty Drug Program will change from Preferred Choice to Exclusive Choice.	
	Method of Claim Submission	Pay Direct Drug Card	
	Drug Plan Type	◯ **Mandatory Generic Substitution** ◯ **Generic**	
	Preferred Choice Actively Managed Drug Solutions – Maintenance Drugs		
	Coinsurance		
	Express Scripts Canada Pharmacy – Maintenance Drugs		
	ESC Pharmacy/Retail Pharmacy		
	Flat	a) 80%/60% b) 90%/70% c) 100%/80%	_____ _____ _____ _____ _____
	Graded (If differs by class, please indicate in the EHB notes section)	ESC Pharmacy _____ % of first $ _____ , 100% thereafter Retail Pharmacy _____ $ of first $ _____ , 80% thereafter	
	All Other Drugs		
	ESC Pharmacy/Retail Pharmacy		
	Flat	a) 80% b) 90% c) 100%	_____ _____ _____ _____ _____
	Graded (If differs by class, please indicate in the EHB notes section)	_____ % of first $ _____ , 100% thereafter	

28	**Deductible**		
	Express Scripts Canada Pharmacy – Maintenance Drugs		
	ESC Pharmacy/Retail Pharmacy	$0/$0 (Plan will pay up to the Provincial Reasonable and Customary Dispensing Fee)	
	All Other Drugs		
	Retail Pharmacy	$0 (Plan will pay up to the Provincial Reasonable and Customary Dispensing Fee)	
	Maximum		
	(Applicable to all drugs except Specialty classes listed below)		
	All Plan Types	Unlimited, or $500 to $10,000 in $500 increments. Indicate per certificate or per Insured) (I)	_____ _____ _____ _____ _____
	Specialty Classes		
	Smoking Cessation – Lifetime Maximum	Yes/No $100 - $700 in $50 increments	_____ _____ _____ _____ _____
	Sexual Dysfunction – Annual Maximum	Yes/No $0, $500, $750, $1,000, $1,500	_____ _____ _____ _____ _____
	Fertility Drugs – Lifetime Maximum	Yes/No $0, $2,500, $4,000, Other	_____ _____ _____ _____ _____
	Exclusive Actively Managed Drug Solutions – Maintenance Drugs		
	Coinsurance		
	Express Scripts Canada Pharmacy – Maintenance Drugs		
	ESC Pharmacy/Retail Pharmacy		
	Flat	a) 80%/60% b) 90%/70% c) 100%/80%	_____ _____ _____ _____ _____
	Graded (If differs by class, please indicate in the EHB notes section)	ESC Pharmacy _____ % of first $ _____ , 100% thereafter Retail Pharmacy _____ $ of first $ _____ , 80% thereafter	
	All Other Drugs		
	ESC Pharmacy/Retail Pharmacy		
	Flat	a) 80% b) 90% c) 100%	_____ _____ _____ _____ _____
	Graded (If differs by class, please indicate in the EHB notes section)	_____ % of first $ _____ , 100% thereafter	
	Deductible		
	Express Scripts Canada Pharmacy – Maintenance Drugs		
	ESC Pharmacy/Retail Pharmacy	$0/Dispensing Fee	
	All Other Drugs		
	Retail Pharmacy	$0 (Plan will pay up to the Provincial Reasonable and Customary Dispensing Fee)	
	Maximum		
	(Applicable to all drugs except Specialty classes listed below)		
	All Plan Types	Unlimited, or $500 to $10,000 in $500 increments. Indicate per certificate or per Insured) (I)	_____ _____ _____ _____ _____
	Specialty Classes		
	Smoking Cessation – Lifetime Maximum	Yes/No $100 - $700 in $50 increments	_____ _____ _____ _____ _____
	Sexual Dysfunction – Annual Maximum	Yes/No $0, $500, $750, $1,000, $1,500	_____ _____ _____ _____ _____
	Fertility Drugs – Lifetime Maximum	Yes/No $0, $2,500, $4,000, Other	_____ _____ _____ _____ _____

28 Major Medical – Choose Option 1 (Standard) or Option 2 (Healthcare Essentials)

◯ Option 1: Standard Extended Healthcare

Coinsurance Applicable to Major Medical, **EXCEPT**, Hospital, Paramedical, Vision Care, Eye Exam, and Emergency Travel Assistance	50% to 100% in 5% increments	_____ _____ _____ _____ _____
Deductible (not combined with drug deductible)	$0/$0, $25/ $50, $50/$100, $100/$200, $250/$500, Other	_____ _____ _____ _____ _____
Eye Exams	Yes or No	_____ _____ _____ _____ _____
Coinsurance (*default)	◯ 70% ◯ 75% ◯ 80%* ◯ 90% ◯ 100%	_____ _____ _____ _____ _____
Maximum per Insured	$75, $100, $150, $200	_____ _____ _____ _____ _____
Benefit Period – Adult	24 months	
Benefit Period – Dependant Children	12 months or 24 months	_____ _____ _____ _____ _____
Vision Care	Yes or No	_____ _____ _____ _____ _____
Deductible	Subject to Major Medical Deductible? Yes or No	_____ _____ _____ _____ _____
Coinsurance	◯ 70% ◯ 75% ◯ 80% ◯ 90% ◯ 100%	_____ _____ _____ _____ _____
Maximum per Insured	$100, $150, $ 200, $300, $500	_____ _____ _____ _____ _____
	$100 and $150 maximums will be extended to $200 over 12/24 months for contact lenses (if necessary for 20/40 visual acuity)	
Benefit Period – Adult	24 months	
Benefit Period – Dependant Children	12 months or 24 months	_____ _____ _____ _____ _____
Hospital		
Semi-Private	Yes or No	_____ _____ _____ _____ _____
Deductible	Subject to Major Medical Deductible? Yes or No	_____ _____ _____ _____ _____
Coinsurance	◯ 70% ◯ 75% ◯ 80% ◯ 90% ◯ 100%	_____ _____ _____ _____ _____
Private (includes Semi-Private)	Yes or No	_____ _____ _____ _____ _____
Coinsurance	◯ 70% ◯ 75% ◯ 80% ◯ 90% ◯ 100%	_____ _____ _____ _____ _____
Convalescent Hospital	Yes or No	_____ _____ _____ _____ _____
Deductible	Subject to Major Medical Deductible? Yes or No	_____ _____ _____ _____ _____
Coinsurance	Matches Major Medical Coinsurance or Other (50% to 100% in 5% increments)	_____ _____ _____ _____ _____
Daily Maximum	$20, $40, Other	_____ _____ _____ _____ _____
Maximum	90 days, 120 days or 180 days	_____ _____ _____ _____ _____
Specialized Treatment Facility	Yes or No	_____ _____ _____ _____ _____
Deductible	Subject to Major Medical Deductible? Yes or No	_____ _____ _____ _____ _____
Coinsurance	Matches Major Medical Coinsurance or Other (50% to 100% in 5% increments)	_____ _____ _____ _____ _____
Daily Maximum	$20, $40, Other	_____ _____ _____ _____ _____
Lifetime Maximum	up to $4,000	_____ _____ _____ _____ _____

28			
	Orthopaedic Supplies		
	Maximum per Insured		
	Inserts	$200, $300, $400, $500	
	Shoes, OR	$200, $300, $400, $500	
	Combined Maximum	$300, $400, $500, $700, $800, $1,000	
	Diagnostic Laboratory Procedures		
	Maximum per Insured	$500, $1,000, $1,500, or Unlimited	
	Hearing Aids		
	Benefit Period	3, 4, or 5 years	
	Maximum	$300, $500, $750, $1,000	
	Private Duty Nursing		
	Maximum per Insured	$5000 to $25,000, maximum per year	
	Emergency Travel Assistance Program		
	Coinsurance	100%	
	Deductible	$0/$0	
	Trip Duration, Continuous Coverage	60 days, 90 days, 120 days	
	Lifetime Maximum per Insured	$5,000,000	
	Out-Of Province Referral Lifetime Maximum per Insured	$15,000 (combined)	
	Travel Assistance	Included	
	Paramedical Services	Yes or No	

Select Option A (Traditional) **OR Option B** (Bundled) **OR choose No** and select IHE or HCSA

○ **Option A: Traditional** (Provides coverage options grouped by type of Practitioner)
You choose which practitioners to include in coverage by selecting one of the following three groups, for each class, where covered.

Included Practitioners:
Basic – Chiropractor, Physiotherapist, Psychologist/Social worker (combined)
Standard (default) **–** All Basic + Acupuncture, Registered Dietician, Occupational Therapist, Audiologist, Speech Therapist
Plus – All Standard + Massage Therapist, Podiatrist/Chiropodist (combined) Naturopath, Osteopath

Choose one of three options (*default)	**Basic** **Standard*** (includes Basic) **Plus** (includes Basic and Standard)	
Coinsurance (*default)	70%, 75%, 80%*, 90%, 100%	
Annual Maximum		
Per Certificate, All Practitioners Combined (*default) (**Plus only)	$300, $400, $500*, $750, $1,000**	
Per Insured, All Practitioners Combined (*Plus only)	$300, $400, $500, $750, $1,000*	
Per Certificate, Per Practitioner	$300, $400, $500, $750	
Per Insured, Per Practitioner	$300, $400, $500, $750	
Per Visit Maximum	Yes or No	
Per Visit Maximum Amount	$25, $35, $50, $75	

28 **OR CHOOSE ◯ Option B: Bundled**

Provides coverage for all Practitioners, bundled together with different combined maximums and you choose a per bundle maximum amount.

Included Practitioners (cannot select between bundles):

Bundle 1 – Physiotherapist, Psychologist, Social Worker, Registered Dietician, Occupational Therapist, Audiologist, Speech Therapist

Bundle 2 – Chiropractor, Massage Therapist, Podiatrist, Chiropodist

Bundle 3 – Acupuncture, Naturopath, Osteopath

Coinsurance (*default)	◯ 70% ◯ 75% ◯ 80%* ◯ 90% ◯ 100%			_____ _____ _____ _____ _____
Maximum basis (*default)	◯ Per Certificate* ◯ Per Insured			_____ _____ _____ _____ _____
Annual Maximum, per bundle (*default) (**only available per certificate)	**Bundle 1**	**Bundle 2**	**Bundle 3**	_____ _____ _____ _____ _____
	a) ◯ $500* b) ◯ $750 c) ◯ $1,000	$300 $500 $750	$200, OR $300, OR $500**	_____ _____ _____ _____ _____
Per visit Maximum	◯ Yes ◯ No			_____ _____ _____ _____ _____
Per Visit Maximum Amount	◯ $25 ◯ $35 ◯ $50 ◯ $75			_____ _____ _____ _____ _____

◯ OPTION 2: Healthcare Essentials (all classes are covered, where applicable)

Mandatory Benefits

Private Duty Nursing	Included at 100% Coinsurance, $10,000 maximum
Medical Supplies	Included at 100% Coinsurance – all standard limits apply
Pay Direct Drug Plan	The benefit options selected under Drugs will apply with the exception of the following: • If Optional Benefit selected – excludes Sexual Dysfunction, Fertility Drugs • If Optional Benefit NOT selected – excludes above plus Smoking Cessation
Emergency Travel Assistance Program	100% Coinsurance, $5,000,000 Lifetime Maximum, Per Insured
Trip Duration, Continuous Coverage	◯ 60 days ◯ 90 days ◯ 120 days
◯ **Optional Benefits**	Include at 100% Coinsurance or Exclude
Included	Semi-Private Hospital, Paramedical Services, Vision, Eye Exams
Deductible	$0/$0
Combined Maximum, per Certificate	$500, $1,000

Incidental Health Expense (Optional) ◯ Yes or ◯ No

Can be selected with Option 1 or Option 2

Maximum		**CLASS**
Annual Single	$100-$5,000 in $25 increments	_____ _____ _____ _____ _____
Annual Family	$100-$5,000 in $25 increments	_____ _____ _____ _____ _____

Notes: Indicate any deviations and/or special considerations

29 Health Care Spending Account (HCSA) (optional) ◯ Yes ◯ No

Coverage does not have to apply to all classes, but must apply to all insured employees within a class.
Standard Funding Option: Monthly reconciliation

Benefit Period ◯ Calendar year ◯ Benefit year

Grace Period ◯ 90 day ◯ 180 day

Select **either** Balance Carry Forward account type **or** No Balance Carry Forward account type:

◯ **Balance Carry Forward**

Division: _____ _____ _____ _____ _____

Class: _____ _____ _____ _____ _____

Administration Fee _____ _____ _____ _____ _____

Prorate new employees (Y or N) _____ _____ _____ _____ _____

Coordination with EHB and Dental (Y or N)
Yes (recommended) _____ _____ _____ _____ _____

Allocation: Annual (A) Semi Annual (S) Quarterly (Q) _____ _____ _____ _____ _____

Amount (per Benefit Period):
Benefit amount can vary beginning at $100 to a maximum of $10,000 annually — Single ($) _____ _____ _____ _____ _____

OR
$50 to a maximum of $2,500 quarterly/semi-annually — Family ($) _____ _____ _____ _____ _____

◯ **No Balance Carry Forward**

Division: _____ _____ _____ _____ _____

Class: _____ _____ _____ _____ _____

Administration Fee

Prorate new employees (Y or N) _____ _____ _____ _____ _____

Coordination with EHB and Dental (Y or N)
Yes (recommended) _____ _____ _____ _____ _____

Allocation: Annual (A) _____ _____ _____ _____ _____

Amount (per Benefit Period):
Benefit amount can vary beginning at $100 to a maximum of $10,000 annually — Single ($) _____ _____ _____ _____ _____

Family ($) _____ _____ _____ _____ _____

30 Dental Benefit ◯ Yes ◯ No

Note "All" in the Class row if coverage applies to all classes **and** coverage details are the same for all classes.

Division: _____ _____ _____ _____ _____

Class: _____ _____ _____ _____ _____

Benefit Period	Matches EHB choice	
Orthodontics	Lifetime	
Termination Age*	Matches EHB choice	
Maximum Basis		
Basic Restorative, Periodontic–Endodontic	◯ Per Insured ◯ Per Certificate	_____ _____ _____ _____ _____
Major Restorative	◯ Per Insured ◯ Per Certificate	_____ _____ _____ _____ _____
Orthodontic	Per Insured	
Survivor Benefit	◯ None ◯ 1 year ◯ 2 years	

* The termination age for insured dependant children is the attainment of age 22, 26 if full-time student at an accredited educational institution. Termination age for Dependant's Orthodontic coverage is the attainment of age 20.

Basic Restorative, Periodontic–Endodontic

Coinsurance		
Basic Restorative	60% to 100% in 5% increments	_____ _____ _____ _____ _____
Periodontic-Endodontic	60% to 100% in 5% increments	_____ _____ _____ _____ _____
Deductible (Single/Family)	$0/$0, $25/ $50, $50/ $100, Other	_____ _____ _____ _____ _____
Maximum	$500 to $5,000 in $250 increments, or unlimited	_____ _____ _____ _____ _____
Scaling Units (1 unit = 15 mins)	6 to 16 in 1 unit increments	_____ _____ _____ _____ _____
Recall	6, 9, or 12 months	_____ _____ _____ _____ _____

Major Restorative

Coinsurance	50% to 80% in 5% increments	_____ _____ _____ _____ _____
Maxiumum		
Major Restorative only	$500 to $5,000 in $250 increments	_____ _____ _____ _____ _____
Basic Restorative, Periodontic-Endodontic and Major Restorative combined	$500 to $5,000 in $250 increments	_____ _____ _____ _____ _____

Orthodontics

Coinsurance	50%-60%	_____ _____ _____ _____ _____
Deductible	$0	
Adults Included?	Yes or No	_____ _____ _____ _____ _____
Lifetime Maximum	$1,000 to $7,000, in $500 increments	_____ _____ _____ _____ _____

Fee Guide

Fee Guide	Standard or Deluxe (additional 25%)	_____ _____ _____ _____ _____
Year	Fixed year (indicate year) or Current year	_____ _____ _____ _____ _____
Practitioner Guide	◯ General ◯ Specialist	_____ _____ _____ _____ _____
Province	◯ Employee province of residence (default) or ◯ Province of Policyowner's primary business location	

30. Dental Flex ◯ Yes ◯ No

Combined Basic, and Restorative, Periodontic-Endodontic, Major restorative, and Orthodontic		
Eligibility	Orthodontic for Dependent Children up to and including age 19	
Benefit period	Matches EHB Benefit Period	
Survivor Benefit	Included for 2 years	
Maximum Basis	◯ Per Insured ◯ Per Certificate	
Deductible	$0	
Coinsurance	◯ 80% ◯ 100%	_____ _____ _____ _____ _____
Annual Combined Maximum	◯ $750 ◯ $1,000 ◯ $1,500 ◯ Other $ _____ ($500 to $3,000 in increments of $250)	_____ _____ _____ _____ _____
Recall	◯ 6 months ◯ 9 months ◯ 12 months	_____ _____ _____ _____ _____
Scaling Units	◯ 12 ◯ 15 ◯ Other _____ (6 to 16 in 1 unit increments)	_____ _____ _____ _____ _____
Fee Guide	◯ Standard ◯ Deluxe (additional 25%)	_____ _____ _____ _____ _____
Year	◯ Current ◯ Fixed (provide year)	_____ _____ _____ _____ _____
Practitioner	General	
Province	◯ Employee Province of Residence ◯ Province of Policyowner's primary business location	

31 Corrections / Amendments / Clarifications (For Applicant use)

32 PAD (Pre-authorized Debit) Agreement

◯ I/we hereby authorize Empire Life to withdraw the amount due on my billing statement from my financial institution account*.

* Pre-authorized debit is mandatory for ASO customers

Monthly withdrawal date - Indicate the day of the month the withdrawal is to be processed* (1st to 25th) _____ If no date selected, withdrawals will be on the 10th of the month.

* The withdrawal from your bank account may occur up to two business days after this date.

Financial Institution account to be debited: ◯ Account shown on the attached void cheque.

Be aware that certain recourse rights exist in the event that a debit does not comply with this agreement. You 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 your recourse rights, please contact your financial institution or visit www.cdnpay.ca.

Please attach a void cheque

33 Ontario Retail Sales Tax (RST) – Election Form

DECLARATION

◯ Yes, the Applicant for this Group Insurance Policy elects to remit the full Ontario Retail Sales Tax payable on both the employee and employer premiums to The Empire Life Insurance Company in accordance with subsection 3.1(3) or 3.2(3), as applicable, of Regulation 1013 of the Revised Regulations of Ontario, 1990 made under the Retail Sales Tax Act.

To be used:

a) If you are/would be licensed under the Retail Sales Tax Act in order to submit RST on employee premiums due on a Group Insurance Policy only. (Subsection 3.2(3))

b) If you are a licensed vendor under the Retail Sales Tax Act but you want The Empire Life Insurance Company to submit the RST on employee premiums. (Subsection 3.1(3))

34 **Corrections / Amendments / Clarifications** (Empire Life Head Office Use Only)

35 Declarations, Authorizations and Signatures (Signatures must be originals)

The Applicant hereby declares that:

(1) the statements and answers above shall constitute the Application for and form part of the Contract. As such, errors or misrepresentation of information may invalidate coverage, and the Applicant certifies that the answers given and the information in this Application and in other documents supporting this Application for benefits are true, full, and complete;

(2) in the event the Applicant forms part of a Limited Liability Partnership, all parties belonging to the Limited Liability Partnership consent and authorize the Applicant to enter into and bind the Limited Liability Partnership in respect to this Contract;

(3) the insurance will become effective in accordance with and subject to the terms and conditions of 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 (Empire Life);

(4) the Applicant has obtained individual plan member consent to the collection, use and disclosure of plan member personal information (including personal information about plan member dependant(s)) required for plan enrolment and ongoing administration of the plan;

(5) Each of the Plan Administrators listed in Section 3 of this Application will be able to view and update employee information regarding the group policy on the Plan Administrator website (with the exception of detailed claim information) until they are removed as Plan Administrator; and

(a) I confirm that I have read, understood and agree to the Terms and Conditions for Online Administration of Policy, which shall be binding on me, my successors, and permitted assigns.

(6) the Applicant confirms the appointment of the Advisor(s) identified in Section 36 of this Application to act as the Consultant/Agent of Record for this policy. It authorizes said Consultant/Agent of Record to:

(a) receive any information that may be requested regarding existing plans, future plans, or quotations on the insurance plan from any insurance company or other organizations administering such plans. Information released will not include plan member's detailed claims information; and

(b) view employee and plan design details on the Plan Administrator website; and

(c) receive any commissions in respect to any existing or future contracts pertaining to the Employee Benefits Plan.

This appointment will remain in effect until revoked by the Applicant in writing.

In the case of errors or omissions discovered by Empire Life in the Application, Empire Life is hereby authorized to amend the Application by noting the change in section 34 entitled "Corrections/Amendments/Clarifications". Acceptance by the Applicant of the Policy accompanied by a copy of this Application so amended, shall constitute ratification of such "Corrections/Amendments/Clarifications".

The Applicant understands and agrees that:

- the pre-authorized debit agreement as indicated in Section 32 can be terminated, upon written notification, at any time on ten days notice, by either Empire Life or by the Applicant;
- cancellation of the pre-authorized debit agreement does not constitute cancellation of service by Empire Life and the Applicant shall be liable for any past, present or future amounts owing;
- for the purposes of the pre-authorized debit agreement, all debits from the Applicant's account will be treated as personal; and
- to obtain a sample cancellation form or for more information on the right to cancel a PAD arrangement, the Applicant may contact its financial institution or visit www.cdnpay.ca.

The Applicant authorizes Empire Life to withdraw monthly premium payments as required, as per the Applicant's instructions in Section 32, and the Applicant understands that these amounts may be variable and increase or decrease.

The Applicant waives the right to notice before any withdrawal is made and also the right to notice of any change in the amount of automatic withdrawal.

An initial Premium Deposit Cheque in the sum of $ _____ is included with this Application. The amount of the Premium Deposit is the estimated value of the first month's premium. Negotiation of the cheque will not, of itself, constitute approval of the Application.

Completed and signed at _____ this _____ day of _____.
(City and Province) (Month) (Year)

for _____
Applicant - Full Company Legal Name (PLEASE PRINT)

by _____
Signature of Authorized Company Official PRINT Name/Title in FULL

by _____
Signature of Witness PRINT Name/Title in FULL

36 Advisor's Information

Advisor's Commitment: To the best of my/our knowledge and belief all statements in this Application are true and complete. I/we have read and understand the form. I have advised the Applicant not to terminate any existing coverage until notice has been received that the coverage being applied for is accepted.

I have provided to the Applicant a statement of disclosure outlining the fact that I may receive compensation in the form of commissions, bonuses, conference programs or other incentives, and any conflicts, or potential conflicts of interest. I am not aware of any additional information material to the underwriting and acceptance of this Application for Group Insurance.

	Use this column if there are two Advisors
Date	
Company Name	
Address – Street/Suite	
City, Province	
Postal Code	
Telephone	
Fax	
Email Address	
Group Office	
Empire Life Advisor Code	
Percentage of Case	
Name of Advisor – Print name in full	Name of Second Advisor – Print name in full
Signature of Advisor **X**	**Signature of Second Advisor** **X**

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 employees and that additional evidence requirements have been communicated to employees.

3) A copy of the current billing from the current carrier is enclosed, showing in-force volumes by employee if present coverage in-force.

4) A cheque for the first month's estimated 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.

Application for *AssistNow* Employee Assistance Plan (EAP)

Legal name of company			
Address	City	Province	Postal code
Effective date of EAP plan	**Initial employee population in plan**		
Name of authorized representative	Title		
Email	Phone number		
Empire Life Group #			

AssistNow EAP services ("EAP Services") are delivered and administered by Aspiria Corp. ("Aspiria"). All EAP Services must be requested directly from Aspiria and do not form part of the Empire Life Group Contract.

EAP Services include: 24/7 Clinical Response Centre, Assessment Counselling, and Referral Services, Life Coaching Wellness Service, Smoking Cessation Treatment, access to the Worklife and Wellness portal, and the Information/Referral Centre. Documentation outlining EAP Services and the EAP Service Agreement will be sent to you directly by Aspiria.

Aspiria rate: $3.95 per employee per month plus HST/GST/QST as applicable. Aspiria will invoice you to cover the first monthly premium based on the initial employee population.

EAP Services will take effect after this application is accepted by Aspiria and on the effective date approved by Aspiria.

You hereby consent to disclose aggregate utilization data to Empire Life (no identifying personal data will be reported).

Signature of authorized representative **X**	Dated this _____ day of _____ _____

Contact Information

Plan Administrator name			
Email	Phone number		
Advisor name			
Advisor firm			
Address	City	Province	Postal code
Email	Phone number		
Empire Life Account Manager	Email	Phone number	
Empire Life Account Executive	Email	Phone number	