20PLUS
APPLICATION FOR GROUP INSURANCE

Policies are issued by:

The Empire Life Insurance Company

Empire Life
259 King Street East
Kingston ON K7L 3A8

empire.ca • 1 800 561-1268

Empire Life

APPLICATION FOR GROUP INSURANCE

If more space is required to complete a section, please include details in section 4.12.

1. Policyowner/Group Information

1.1 Policyowner/Applicant

Registered legal name:

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

Address (number, street)	City	Province	Postal code

1.2 Plan Administrator

Plan Administrator #1 (name)	Telephone	Email address
Plan Administrator #2 (name)	Telephone	Email address

1.3 Type of Business (goods or services provided)

1.4 Ownership

Select one: ○ Sole Proprietorship   ○ Partnership   ○ Corporation   ○ Limited Liability Partnership

Name(s) of Owner(s), if Sole Proprietorship, Partnership or Limited Liability Partnership

1.5 Affiliated Companies – to be included? ○ **Yes** ○ **No**

If more than 1 affiliated company, complete and **attach a list** of affiliated companies.
Is billing sub-totalling required?   ○ Yes ○ No – if yes, complete Section 13.

Division	Legal Name	Name to appear on booklet and benefit cards

Address (number, street)	City	Province	Postal code

Plan Administrator (name)	Telephone	Email address

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

Nature of Business	Number of Employees in affiliated company:

1.6 REQUESTED EFFECTIVE DATE for all coverage is 12:01 a.m. **EST** on:

         (day),   (month),   (year).

FIRST YEAR RENEWAL DURATION:
15 months

1.7 Present Coverage ○ **Yes** ○ **No**

If yes, provide a full copy of your most recent **billing statement** (no more than 2 months old) and your most current **Intercompany EP3 statement**.

Carrier	Will insurance replace similar coverage? ○ Yes ○ No	Proposed cancellation date

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.

2. Employee Information

2.1 Divisions and Class Descriptions

Division #	Class	Class Description
_____	_____	_____
_____	_____	_____
_____	_____	_____

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

2.2 Definition of Salary (check 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:

2.3 Total Number of Employees

As of policy effective date, total number of employees to be insured _____ Total of payroll _____

a) Employees must be actively at work a minimum of **20 hours per week,** reside in Canada, with provincial health coverage, and be employed on a permanent basis in Canada, or indicate the minimum hours per week, if different from above: _____ hours

Are there any employees excluded from coverage? ○ Yes ○ No – Explain why:

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

2.4 Participation Requirements (Minimum 25% employer contribution required)

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.

2. Employee Information (cont'd)

2.5 Policyowner Premium Contributions

Division: _____ _____ _____
Class: _____ _____ _____

Indicate the percentage of the cost to be paid by **the Policyowner** for each benefit.

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	_____ _____ _____

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.

2.6 Waiting Period

Division: _____ _____ _____
Class: _____ _____ _____

3 or 6 Months or **other** (please specify) of continuous employment: _____ _____ _____

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

2.7 Lay-off/Leave of Absence provisions

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.

2.8 Workplace Safety Legislation

Are all employees covered by provincial workplace safety legislation (e.g. WSIB, WCB/CSST. WorkSafe (B.C.)

○ Yes   ○ No– If "No", Industry exempt? ○ Yes   ○ No

○ Yes   ○ No– If "No", indicate those employees who are not covered: _____

2.9 Are Benefits Union negotiated? ○ **Yes**   ○ **No**

If yes, Include a complete copy of the Union Collective Agreement and answer questions below.

(i) Are all Classes **Union** negotiated?   ○ Yes   ○ No**
     ** If **No**, indicate which Classes are **Union** negotiated:

(ii) Date of last **Union** negotiation: _____

2.10 Employee Classification

Are any proposed employees/insured 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

2. Employee Information (cont'd)

2.11 **Employees Not Actively at Work** ○ **Yes** ○ **No**

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)	Reason code for absence	Date of leave or disability	Expected return to work	Claim Type (For employees listed with Reason code (iv) or (viii) inclusive, provide details of claim below)	Applied for	Approved
					○ Workplace safety benefits ○ WI ○ EI ○ LTD ○ Life Waiver of Premium	○ Yes ○ No	○ Yes ○ No
					○ Workplace safety benefits ○ WI ○ EI ○ LTD ○ Life Waiver of Premium	○ Yes ○ No	○ Yes ○ No
					○ Workplace safety benefits ○ WI ○ EI ○ LTD ○ Life Waiver of Premium	○ Yes ○ No	○ Yes ○ No
					○ Workplace safety benefits ○ WI ○ EI ○ LTD ○ Life Waiver of Premium	○ Yes ○ No	○ Yes ○ No
					○ Workplace safety benefits ○ WI ○ EI ○ LTD ○ Life Waiver of Premium	○ Yes ○ No	○ Yes ○ No

3. 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: _____ _____ _____

Fully Insured Rates Class: _____ _____ _____

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 _____ _____ _____

3. Unit Premium Rates (cont'd)

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.

4. Schedule of Benefits

Note "all" in the divison/class row if coverage applies to all classes and coverage details are the same for all classes.

4.1 EMPLOYEE LIFE BENEFIT ○ Yes ○ No **EMPLOYEE AD&D BENEFIT** ○ Yes ○ No

a) Division/Class	_____/_____	_____/_____	_____/_____
b) Life Schedule*	_____	_____	_____
c) Life Maximum	$_____	$_____	$_____
d) AD&D Schedule*	_____	_____	_____
e) AD&D Maximum	$_____	$_____	$_____
f) Reduction Schedule at age 65	_____	_____	_____
g) Reduction Schedule at age 70 (if terminates at age 75 or later)	_____	_____	_____
h) 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.

4. Schedule of Benefits (cont'd)

4.2 EMPLOYEE OPTIONAL LIFE ○ Yes ○ No   EMPLOYEE OPTIONAL AD&D ○ Yes ○ No

a) Divison/Class	_____/_____	_____/_____	_____/_____
b) Optional Life Schedule	_____	_____	_____
c) Optional Life Maximum	$_____	$_____	$_____
d) Optional AD&D Schedule	_____	_____	_____
e) Optional AD&D Maximum	$_____	$_____	$_____
f) Reduction Schedule	○ None ○ 50% at age 65	○ None ○ 50% at age 65	○ None ○ 50% at age 65
g) Termination Age	○ 65 ○ 70	○ 65 ○ 70	○ 65 ○ 70

Evidence of Insurability is required for all amounts of Employee Optional Life Benefits. The minimum coverage is $10,000.

4.3 DEPENDANT LIFE ○ Yes ○ No

a) Division/Class	_____/_____	_____/_____	_____/_____
b) Spouse Amount	$_____	$_____	$_____
c) Dependant Child Amount	$_____	$_____	$_____
d) 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.

4.4 SPOUSAL OPTIONAL LIFE ○ Yes ○ No (Only available if Employee Optional Life selected)
SPOUSAL OPTIONAL AD&D ○ Yes ○ No (Only available if Spousal Optional Life selected)

a) Divison/Class	_____/_____	_____/_____	_____/_____
b) Spousal Optional Life Schedule	_____	_____	_____
c) Spousal Optional Life Maximum	$_____	$_____	$_____
d) Spousal Optional AD&D Schedule	_____	_____	_____
e) Spousal Optional AD&D Maximum	$_____	$_____	$_____
f) Reduction Schedule at age 65	○ None ○ 50% at age 65	○ None ○ 50% at age 65	○ None ○ 50% at age 65
g) Termination Age	○ 65 ○ 70	○ 65 ○ 70	○ 65 ○ 70

Evidence of Insurability is required for all amounts of Spousal Optional Life Benefits.

4. Schedule of Benefits (cont'd)

4.5 GROUP CRITICAL ILLNESS (CI) (Minimum 3 Critical Illness Lives. Can vary by class.)   Rates: See appendix

Choose:
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)

	Employee CI ○ Yes ○ No Available for groups with a minimum of 3 Critical Illness lives. Can vary by class.			Spousal CI ○ Yes ○ No Only available if Employee CI selected. Must select the same type of coverage within each class. Spouse coverage cannot exceed employee coverage.			Dependant CI ○ Yes ○ No Only available if Employee CI selected. **Complete Traditional** (15 conditions. Partial/multiple/ cancer recurrence benefits not available for dependent children.)		
a) Division/Class	___/___	___/___	___/___	___/___	___/___	___/___	___/___	___/___	___/___
b) Type of coverage	○ VACI ○ TCI ○ ECI	○ VACI ○ TCI ○ ECI	○ VACI ○ TCI ○ ECI	○ TCI ○ ECI	○ TCI ○ ECI	○ TCI ○ ECI	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
c) Benefit Amounts	$10,000-$250,000			$10,000-$25,000			$5,000 per child		
	$_____	$_____	$_____	$_____	$_____	$_____			
d) Termination Age	VACI – 65 TCI/ECI - 70			Employee age 70			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.		
e) Reduction Schedule	VACI – None TCI/ECI – 50% AT AGE 65			50% AT AGE 65			N/A		
f) No Evidence Limit	VACI–N/A TCI/ECI - $_____			No medical underwriting required			No medical underwriting required		
g) Waiver of Premium	VACI – Not included TCI/ECI – Included			Included			Included		
h) Pre-existing Condition Exclusion Period (Employee choice also applies to Spouse and Dependant coverage)	VACI – N/A TCI/ECI – ○ 24/24 ○ 12/12 (50+ lives) ○ 0/0 (200+ lives)								

4.6 OPTIONAL GROUP CRITICAL ILLNESS (Must have Employee CI to select Optional CI)   Rates: See appendix

	Employee Optional CI ○ Yes ○ No Must have Employee CI to select Optional CI.			Spousal Optional CI ○ Yes ○ No Only available if Employee CI selected – and must select the same type of coverage within each class.			Dependant Optional CI ○ Yes ○ No Only available if Optional Employee CI selected. **Complete Traditional** (15 conditions) Partial/multiple/ cancer recurrence benefits not available for dependent children.)		
a) Division/Class	___/___	___/___	___/___	___/___	___/___	___/___	___/___	___/___	___/___
b) Type of Coverage	○ TCI ○ ECI	○ TCI ○ ECI	○ TCI ○ ECI	○ TCI ○ ECI	○ TCI ○ ECI	○ TCI ○ ECI	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
c) Benefit Amounts	$10,000-$250,000			$10,000-$250,000			$5,000-$25,000		
	$_____	$_____	$_____	$_____	$_____	$_____	$_____	$_____	$_____
d) Termination Age	65			Employee Age 65			Employee Age 65		
e) No Evidence Limit	Full medical underwriting req'd			Full medical underwriting req'd			No medical underwriting req'd. Pre-existing exclusion applies.		
f) Waiver of Premium	Included								

4. Schedule of Benefits (cont'd)

4.7 WEEKLY INDEMNITY (SHORT TERM DISABILITY) ○ Yes ○ No

a) Division/Class	_____ / _____	_____ / _____	_____ / _____
b) Percentage of Weekly Earnings*	_____ %	_____ %	_____ %
c) Maximum Weekly Benefit	$_____	$_____	$_____
d) Elimination Period (days)	_____ Injury _____ Sickness	_____ Injury _____ Sickness	_____ Injury _____ Sickness
e) Maximum Benefit Period	_____ Weeks	_____ Weeks	_____ Weeks
e) 1st Day Hospital/Outpatient Surgery	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
f) Termination Age (up to age 70)	_____	_____	_____

g) No Evidence Limit $ _____

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

*If percentage of Weekly Earnings noted in in b) 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.

4.8 LONG TERM DISABILITY ○ Yes ○ No

a) Division/Class	_____ / _____	_____ / _____	_____ / _____
b) Percentage of Monthly Earnings*, or	_____ %	_____ %	_____ %
c) Graded Scale (if differs by class, indicate in section 4.12)	○ 66.67% of the first $2,250, 50% of the next $3,500, 44% of the balance (default), or ○ _____% of the first $_____ , _____% of the next $_____ , and _____% of the first excess		
d) Maximum Monthly Benefit	$_____	$_____	$_____
e) Elimination Period (days)	_____ Injury _____ Sickness	_____ Injury _____ Sickness	_____ Injury _____ Sickness
f) Maximum Benefit Period	○ 2 year ○ 5 year ○ 65 less elimination period	○ 2 year ○ 5 year ○ 65 less elimination period	○ 2 year ○ 5 year ○ 65 less elimination period
g) Own Occupation Period (years)	_____	_____	_____
h) Survivor Benefits	○ None ○ 3 months ○ 6 months	○ None ○ 3 months ○ 6 months	○ None ○ 3 months ○ 6 months
i) Cost of Living Allowance (COLA)	○ No, OR _____%	○ No, OR _____%	○ No, or _____%
Termination Age	65		
No Evidence Limit	$ _____		

*If percentage of Monthly earnings note in b) 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.

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% or the pre-disability Monthly Earnings when the benefits are taxable.

4.9 EXTENDED HEALTHCARE BENEFITS ○ Yes ○ No

Administered in accordance with the requirements of applicable provincial prescription drug legislation and will meet any applicable minimum coverage standards.

Division/Class	_____ / _____	_____ / _____	_____ / _____
Benefit Period	○ Benefit Year (effective date of policy, or 1st of the month following 12 month period) ○ Calendar Year (January-December)		
Termination Age* (60 to 85 years)	_____	_____	_____

*The termination age for insured dependent 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	Threshold is per Insured, per benefit year, and must be the same for all classes.
Threshold	○ $10,000* ○ $15,000* ○ $20,000* ○ $25,000* ○ $7,500 (Drug Only) 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. *For all EHB benefits, excluding Emergency Travel Assistance Program

4.9a) DRUG PLAN

Includes Pay Direct Drug Card, Specialty Drug Program*, and Prior Authorization Drug Program*
*not available in Quebec

Choose:

OPTION 1: STANDARD DRUG PLAN   OR

OPTION 2: MAINTENANCE DRUG PROGRAM
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.

OPTION 1: STANDARD DRUG PLAN

Division/Class	_____/ _____	_____/ _____	_____/ _____
Drug Plan Type			
Prescription By Law Brand (RXA), Generic (RXAG), Mandatory Generic Substitution (RXMG), Provincial Formulary (RXO) **OR** **Prescribed** (over the counter medication included) Brand Name (RXB), Generic (RXBG)	_____	_____	_____
Coinsurance			
○ Flat (50%-100%) **OR**	_____%	_____%	_____%
○ Graded **OR**	_____% of the first $_____, _____% thereafter	_____% of the first $_____, _____% thereafter	_____% of the first $_____, _____% thereafter
○ Tiered: (50-100%) Generic/Brand **OR** Provincial Formulary/Non Prov Formulary	_____% /_____% ○ Generic/Brand **OR** ○ Provincial Formulary /Non Prov Formulary	_____% /_____% ○ Generic/Brand **OR** ○ Provincial Formulary /Non Prov Formulary	_____% /_____% ○ Generic/Brand **OR** ○ Provincial Formulary /Non Prov Formulary
Deductible			
None **OR**	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
Annual (single/family)	$_____(S) / $_____(F)	$_____(S) / $_____(F)	$_____(S) / $_____(F)
Per Prescription ($1-$20)	○ Dispensing Fee **OR** $_____	○ Dispensing Fee **OR** $_____	○ Dispensing Fee **OR** $_____
Dispensing Fee Maximum ($1-$20) (Not applicable to employees and/or eligible dependants residing in Quebec)	○ Empire Life R&C **OR** ○ $_____	○ Empire Life R&C **OR** ○ $_____	○ Empire Life R&C **OR** ○ $_____
Maximum			
All Plan Types, ($500-$10,000) except below:	○ Unlimited **OR** ○ $_____ ○ Per Insured ○ Per Certificate	○ Unlimited **OR** ○ $_____ ○ Per Insured ○ Per Certificate	○ Unlimited **OR** ○ $_____ ○ Per Insured ○ Per Certificate
Smoking Cessation, Lifetime Max ($100-$700)	○ Yes $_____ ○ No	○ Yes $_____ ○ No	○ Yes $_____ ○ No
Sexual Dysfunction Annual Max ($500-$1,500)	○ Yes $_____ ○ No	○ Yes $_____ ○ No	○ Yes $_____ ○ No
Fertility Lifetime Max	○ Yes $_____ ○ No	○ Yes $_____ ○ No	○ Yes $_____ ○ No

4.9a) DRUG PLAN (cont'd)

OPTION 2: MAINTENANCE DRUG PROGRAM (Not available in Quebec)

Division/Class	_____/_____		_____/_____		_____/_____	
Drug Formulary	○ Mandatory Generic Substitution ○ Generic					
	Maintenance Drugs-ESC/Retail	**Other Drugs-Retail***	**Maintenance Drugs-ESC/Retail**	**Other Drugs-Retail***	**Maintenance Drugs-ESC/Retail**	**Other Drugs-Retail***
Coinsurance						
○ Flat **OR**	○ 80%/60% ○ 90%/70% ○ 100%/80%	○ 80% ○ 90% ○ 100%	○ 80%/60% ○ 90%/70% ○ 100%/80%	○ 80% ○ 90% ○ 100%	○ 80%/60% ○ 90%/70% ○ 100%/80%	○ 80% ○ 90% ○ 100%
○ Graded	**ESC** ○____% of the first $_____, 100% thereafter **Retail** ○____% of the first $_____, 80% thereafter	○____% of the first $_____, 100% thereafter	**ESC** ○____% of the first $_____, 100% thereafter **Retail** ○____% of the first $_____, 80% thereafter	○____% of the first $_____, 100% thereafter	**ESC** ○____% of the first $_____, 100% thereafter **Retail** ○____% of the first $_____, 80% thereafter	○____% of the first $_____, 100% thereafter
Deductible	**ESC** - ESC Pharmacy Dispensing Fee **Retail** - Provincial R&C Dispensing Fee and employee will pay the balance	Provincial R&C Dispensing Fee and the employee will pay the balance	**ESC** - ESC Pharmacy Dispensing Fee **Retail** - Provincial R&C Dispensing Fee and employee will pay the balance	Provincial R&C Dispensing Fee and the employee will pay the balance	**ESC** - ESC Pharmacy Dispensing Fee **Retail** - Provincial R&C Dispensing Fee and employee will pay the balance	Provincial R&C Dispensing Fee and the employee will pay the balance
	*Other Drugs that are not available through ESC Pharmacy may be purchased through a Retail Pharmacy and be eligible for reimbursement under this Plan.					
Maximum ($500-$10,000) **Applicable to all drugs except:** Smoking Cessation ($300 lifetime max) Sexual Dysfunction ($1,000 annual max) Fertility (50% coins, $4,000 lifetime max)	○ Unlimited ○ Other $_____ ○ Per Insured ○ Per Certificate Included ○ Yes ○ No ○ Yes ○ No		○ Unlimited ○ Other $_____ ○ Per Insured ○ Per Certificate Included ○ Yes ○ No ○ Yes ○ No		○ Unlimited ○ Other $_____ ○ Per Insured ○ Per Certificate Included ○ Yes ○ No ○ Yes ○ No	

4.9b) MAJOR MEDICAL

Choose:

> **OPTION 1: HEALTHCARE ESSENTIALS** (all classes are covered, where applicable)
> Includes prescription drugs, medical supplies, private duty nursing, a survivor benefit, and emergency travel assistance.
> You have the option to include a Major Medical benefit – semi-private hospital coverage, paramedical services, vision care. **OR**

> **OPTION 2: STANDARD EXTENDED HEALTHCARE**

OPTION 1: HEALTHCARE ESSENTIALS   ○ **Yes**   ○ **No**

MANDATORY BENEFITS

Private Duty Nursing	Included at 100% Coinsurance, $10,000 maximum
Medical Supplies	Included at 100% Coinsurance – all standard limits apply
Drug Plan	Options selected under Drugs will apply. Excludes Sexual Dysfunction and Fertility Drugs.
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 (includes Mandatory Benefits)

Combined Maximum, per Certificate (100% Coinsurance)	○ $500 ○ $1,000 ○ Exclude
Include	Semi-Private Hospital, Paramedical Services, Vision, Eye Exams

4.9b) MAJOR MEDICAL (cont'd)

OPTION 2: STANDARD EXTENDED HEALTHCARE ○ Yes ○ No

Division/Class		_____/_____	_____/_____	_____/_____
Coinsurance - Applicable to Major Medical EXCEPT, Paramedical, Semi-Private Hospital, Vision Care, Eye Examination, and Emergency Travel Assistance	50%-100%	_____	_____	_____
Deductible (not combined with drug deductible)				
Eye Exams	Yes/No Dependent child-12 or 24 months Adults-24 months	_____	_____	_____
Coinsurance	70%-100%	_____	_____	_____
Maximum per insured	$75-$200	_____	_____	_____
Vision Care	Yes/No	_____	_____	_____
Subject to MM Deductible?	Yes/No	_____	_____	_____
Coinsurance	70%-100%	_____	_____	_____
Maximum per insured	$100-$500	_____	_____	_____
Hospital				
Semi- Private	Yes/No	_____	_____	_____
Subject to MM Deductible?	Yes/No	_____	_____	_____
Coinsurance	70%-100%	_____	_____	_____
Private (includes Semi-Private)	Yes/No	_____	_____	_____
Coinsurance	70%-100%	_____	_____	_____
Convalescent	Yes/No	_____	_____	_____
Subject to Major Med Deductible?	Yes/No	_____	_____	_____
Coinsurance	Matches Major Med Coins or 50%-100%	_____	_____	_____
Daily Maximum	$20-$40, Other	_____	_____	_____
Maximum days	90, 120, 180	_____	_____	_____
Specialized Treatment Facility	Yes/No	_____	_____	_____
Subject to MM Deductible?	Yes/No	_____	_____	_____
Coinsurance	Matches MM Coins or 50%-100%	_____	_____	_____
Daily Maximum	$20, $40, Other	_____	_____	_____
Maximum	Up to $4,000	_____	_____	_____
Orthopaedic Supplies	Yes/No	_____	_____	_____
Maximum per Insured Inserts	$200-$500	_____	_____	_____
Shoes, **OR**	$200-$500	_____	_____	_____
Combined	$300-$1,000	_____	_____	_____
Diagnostic Lab Procedures	Included			
Maximum, per Insured	$500-Unlimited	_____	_____	_____
Hearing Aids	Yes/No	_____	_____	_____
Benefit Period	3, 4, 5 years	_____	_____	_____
Maximum	$300-$1,000	_____	_____	_____
Private Duty Nursing	Yes/No	_____	_____	_____
Maximum, per Insured	$5,000-$25,000, maximum per year	_____	_____	_____
Emergency Travel Assistance Program	Included, Coinsurance 100%, Deductible $0, Travel Assistance Included			
Lifetime Maximum, per Insured Out-of-Province Referral Lifetime Maximum, per Insured	$5,000,000 $15,000 (combined)			
Trip Duration	60, 90, 120 days	_____	_____	_____

4.9c) PARAMEDICAL SERVICES ○ Yes ○ No

Choose:

OPTION 1: TRADITIONAL - coverage options grouped by type of practitioner. Choose which practitioners to include. **OR**

OPTION 2: BUNDLED – coverage for all practitioners, bundled together with different combined maximums and you choose a per bundle maximum amount.

Can also select/add Incidental Health Expense (IHE) or a Healthcare Spending Account (HCSA)

OPTION 1: TRADITIONAL

Included Practitioners:

Basic – Chiropractor, Physiotherapist Psychologist/Social Worker (combined)

Standard – All Basic +Acupuncture, Registered Dietician, Occupational Therapist Audiologist Speech Therapist

Plus – All Standard + Massage Therapist Podiatrist/Chiropodist (combined) Naturopath, Osteopath

Division/Class	_____/_____	_____/_____	_____/_____
Choose one of three options	○ **Basic** ○ **Standard** (includes Basic) **OR** ○ **Plus** (includes Basic and Standard)	○ **Basic** ○ **Standard** (includes Basic) **OR** ○ **Plus** (includes Basic and Standard)	○ **Basic** ○ **Standard** (includes Basic) **OR** ○ **Plus** (includes Basic and Standard)
Coinsurance	○ 70% ○ 75% ○ 80% ○ 90% ○100%	○ 70% ○ 75% ○ 80% ○ 90% ○100%	○ 70% ○ 75% ○ 80% ○ 90% ○100%
Annual Maximum	○ $_____ ($300-$750) ○ Per Insured, **Per Practitioner OR** ○ Per Cert, **Per Practitioner**	○ $_____ ($300-$750) ○ Per Insured, **Per Practitioner OR** ○ Per Cert **Per Practitioner**	○ $_____ ($300-$750) ○ Per Insured, **Per Practitioner OR** ○ Per Cert, **Per Practitioner**
	$_____ ($300-$750) ○ $1,000 (Plus Only) ○ Per Certificate, All Practitioners **Combined, OR** ○ Per Insured, All Practitioners **Combined**	$_____ ($300-$750) ○ $1,000 (Plus Only) ○ Per Certificate, All Practitioners **Combined, OR** ○ Per Insured, All Practitioners **Combined**	$_____ ($300-$750) ○ $1,000 (Plus Only) ○ Per Certificate, All Practitioners **Combined, OR** ○ Per Insured, All Practitioners **Combined**
Per visit Maximum	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
Dollar Amount per visit	$_____ ($25-$75)	$_____ ($25-$75)	$_____ ($25-$75)

OPTION 2: BUNDLED

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

Division/Class	_____/_____			_____/_____			_____/_____		
Coinsurance	○ 70% ○ 75% ○ 80% ○ 90% ○100%			○ 70% ○ 75% ○ 80% ○ 90% ○100%			○ 70% ○ 75% ○ 80% ○ 90% ○100%		
Maximum basis	○ Per Certificate ○ Per Insured			○ Per Certificate ○ Per Insured			○ Per Certificate ○ Per Insured		
Annual Maximum, per bundle	Bundle 1	Bundle 2	Bundle 3	Bundle 1	Bundle 2	Bundle 3	Bundle 1	Bundle 2	Bundle 3
Only available per certificate a) b) c)	○ $500 ○ $750 ○ $1,000	$300 $500 $750	$200 $300 $500	○ $500 ○ $750 ○ $1,000	$300 $500 $750	$200 $300 $500	○ $500 ○ $750 ○ $1,000	$300 $500 $750	$200 $300 $500
Per visit Maximum	○ Yes ○ No			○ Yes ○ No			○ Yes ○ No		
Amount	$_____ ($25-$75)			$_____ ($25-$75)			$_____ ($25-$75)		

Notes: Indicate any deviations and/or special considerations

4. Schedule of Benefits (cont'd)

4.10 HEALTHCARE SPENDING ACCOUNT

Choose:

OPTION 1: INCIDENTAL HEALTH EXPENSE (IHE) (INSURED) **AND/OR**

OPTION 2: HEALTHCARE SPENDING ACCOUNT (HCSA) (ASO)

OPTION 1: INCIDENTAL HEALTH EXPENSE (IHE) (INSURED) ○ Yes ○ No			**Rate: included in EHB Rate**
Division/Class	_____/ _____	_____/ _____	_____/ _____
Maximum			
Annual Single ($100–$5,000) OR	$_____	$_____	$_____
Annual Family ($100–$5,000)	$_____	$_____	$_____

OPTION 2: HEALTHCARE SPENDING ACCOUNT (HCSA) (ASO)   ○ 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

Division/Class	_____/ _____	_____/ _____	_____/ _____
Benefit Period	○ Calendar year ○ Benefit year		
Grace Period	○ 90 day ○ 180 day		
Account Type	○ Balance Carry Forward ○ No Balance Carry Forward		
Prorate new employees	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
Coordination with EHB and Dental	○ Yes (recommended) ○ No	○ Yes (recommended) ○ No	○ Yes (recommended) ○ No
Allocation Amount	○ Annually ($100–$10,000) Single $_____ Family $_____ **For Balance Carry Foward Option Only** ○ Semi Annual ($50–$2,500) Single $_____ Family $_____ **OR** ○ Quarterly ($50–$2,500) Single $_____ Family $_____	○ Annually ($100–$10,000) Single $_____ Family $_____ **For Balance Carry Foward Option Only** ○ Semi Annual ($50–$2,500) Single $_____ Family $_____ **OR** ○ Quarterly ($50–$2,500) Single $_____ Family $_____	○ Annually ($100–$10,000) Single $_____ Family $_____ **For Balance Carry Foward Option Only** ○ Semi Annual ($50–$2,500) Single $_____ Family $_____ **OR** ○ Quarterly ($50–$2,500) Single $_____ Family $_____

4. Schedule of Benefits (cont'd)

4.11 DENTAL BENEFITS

Choose:

OPTION 1: DENTAL – FLEX (must be the same for all classes) Combined Basic and Restorative, Periodontic-Endodontic, Major Restorative, and Orthodontic. Orthodontic for dependent children up to and including age 19. **AND/OR**

OPTION 2: DENTAL – STANDARD

OPTION 1: DENTAL – FLEX ○ Yes ○ No – if yes: ○ Insured ○ Administrative Services Only (must be the same for all classes)

Division/Class	_____/_____	_____/_____	_____/_____
Annual Combined Maximum	○ Per Insured ○ Per Certificate		
	$_____	$_____	$_____
Coinsurance	○ 80% ○ 100%	○ 80% ○ 100%	○ 80% ○ 100%
Recall (months)	○ 6 ○ 9 ○ 12	○ 6 ○ 9 ○ 12	○ 6 ○ 9 ○ 12
Scaling Units (1 =15 mins)	_____ (6-16)	_____ (6-16)	_____ (6-16)
Fee Guide – General Practitioner	○ Standard ○ Deluxe (+ 25%)	○ Standard ○ Deluxe (+ 25%)	○ Standard ○ Deluxe (+ 25%)
	○ Current ○ Fixed _____(yr)	○ Current ○ Fixed _____(yr)	○ Current ○ Fixed _____(yr)
	○ Employee Province of Residence ○ Province of Policyowner's primary business location		
Benefit Period	Matches EHB Benefit Period		
Survivor Benefit	Included for 2 years		
Deductible	$0		

OPTION 2: DENTAL – STANDARD ○ Yes ○ No – if yes: ○ Insured ○ Administrative Services Only

	Basic Restorative (B) and Periodontic-Endodontic (P)			Major Restorative ○ Yes ○ No Combined with Basic? ○ Yes ○ No			Orthodontics ○ Yes ○ No Adults Included? ○ Yes ○ No		
Division/Class	____/____	____/____	____/____	____/____	____/____	____/____	____/____	____/____	____/____
Deductible (Single/Family)	$0/$0, $25/$50, $50/$100, Other			Matches Basic			$0/$0		
	$_____(S)	$_____(S)	$_____(S)						
	$_____(F)	$_____(F)	$_____(F)						
Coinsurance	60%-100%			50%-80%			50% - 60%		
	____% (B)	____% (B)	____% (B)	_____%	_____%	_____%	_____%	_____%	_____%
	____% (P)	____% (P)	____% (P)						
Maximum	○ Per Insured ○ Per Certificate			○ Per Insured ○ Per Certificate			○ Per Insured		
	$500-$5,000			$500-$5,000			$1,000-$7,000		
	$_____	$_____	$_____	$_____	$_____	$_____	$_____ Lifetime	$_____ Lifetime	$_____ Lifetime
Scaling Units (6-16) (1 unit=15 mins)	_____	_____	_____	N/A			N/A		
Recall (6, 9, 12 months)	_____	_____	_____	N/A			N/A		
Benefit Period	Matches EHB Choice						Lifetime		
Termination Age	Matches EHB Choice						Insured dependant children – 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.		

4.11 DENTAL BENEFITS (cont'd)

OPTION 2: DENTAL — STANDARD (cont'd)

Survivor Benefit	○ None ○ 1 yr ○ 2 yr	○ None ○ 1 yr ○ 2 yr	○ None ○ 1 yr ○ 2 yr	N/A	N/A
Fee Guide (Deluxe =+25%)	○ Standard ○ Deluxe	○ Standard ○ Deluxe	○ Standard ○ Deluxe	N/A	N/A
Year	○ Current ○ Fixed ____ yr	○ Current ○ Fixed ____ yr	○ Current ○ Fixed ____ yr	N/A	N/A
Practitioner Guide	○ General ○ Specialist	○ General ○ Specialist	○ General ○ Specialist	N/A	N/A
Province	○ Employee's province of residence (Default) ○ Policyowner's province of primary business location				

4.12 Corrections / Amendments / Clarifications (for Applicant use)

5. Applicant Declarations, Authorizations and Signatures (Signatures must be originals)

5.1 PAD (Pre-authorized Debit) Agreement

○ I hereby authorize Empire Life to withdraw the amount due on my billing statement from my financial institution account.
○ Use initial premium cheque for PAD set-up.
○ PAD is to be used for the first premium.

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.payments.ca.

5.2 Plan Administrator Website

a) Each of the Plan Administrators listed in section 1.2 of this Application will be able to view and update employee information regarding the Group policy (with the exception of detailed claim information) until he or she is removed as Plan Administrator.

b) The Applicant authorizes the Advisor (s) identified in Section 6 of this Application to view employee and plan design details on the Plan Administrator website ○ Yes ○ No

5.3 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))

5. Applicant Declarations, Authorizations and Signatures (cont'd) (Signatures must be originals)

5.4   **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 1.2 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 6 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 4.12 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 5.1 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 5.1, 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 **X** _____
            Signature of Authorized Company Official   PRINT Name/Title in FULL

by **X** _____
            Signature of Witness   PRINT Name/Title in FULL

6. Advisor 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	Date
Company Name	Company Name
Address – Street/Suite	Address – Street/Suite
City Province Postal Code	City Province Postal Code
Telephone Fax	Telephone Fax
Email Address	Email Address
Group Office	Group Office
Empire Life Advisor Code	Percentage of Case	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.

Insurance & Investments – Simple. Fast. Easy.®
www.empire.ca   info@empire.ca

Empire Life®

Application for Assist*Now* 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 #			

Assist*NOW* EAP services ("EAP Services") are delivered and administered by HumanaCare. All EAP Services must be requested directly from HumanaCare 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 HumanaCare.

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

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

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 _____ 20 _____

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

Empire Life®