

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

APPLICATION FOR GROUP INSURANCE

1	Policyowner/Applicant (legal name as indicated on employee T4):			
	What name should appear on your Employee Booklets and Benefit Cards? <input type="radio"/> Name above <input type="radio"/> 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): <input type="radio"/> Sole Proprietorship <input type="radio"/> Partnership <input type="radio"/> Corporation <input type="radio"/> 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) <input type="radio"/> Yes <input type="radio"/> No If more than 2 affiliated companies, complete and attach a list of affiliated companies.			
	Affiliated company #1 Are separate billing statements required? <input type="radio"/> Yes <input type="radio"/> 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: <input type="radio"/> Common Ownership <input type="radio"/> Subsidiary <input type="radio"/> Other:			
	Nature of Business:			
	Number of Employees in affiliated company #1:			
	Affiliated company #2 Are separate billing statements required? <input type="radio"/> Yes <input type="radio"/> 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: <input type="radio"/> Common Ownership <input type="radio"/> Subsidiary <input type="radio"/> 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
<input type="radio"/> Life			
<input type="radio"/> A.D.&D.			
<input type="radio"/> Optional Life			
<input type="radio"/> Dependant Life			
<input type="radio"/> Optional AD&D			
<input type="radio"/> Critical Illness			
<input type="radio"/> Weekly Indemnity			
<input type="radio"/> Long Term Disability			
<input type="radio"/> Extended Health			
<input type="radio"/> 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

Schedule

3 Months of continuous employment: _____

6 Months of continuous employment: _____

Other: (specify) _____

Division: _____

Class: _____

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
	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> 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
	<input type="radio"/> Workplace safety benefits <input type="radio"/> WI <input type="radio"/> EI <input type="radio"/> LTD <input type="radio"/> Life Waiver of Premium	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> No
	<input type="radio"/> Workplace safety benefits <input type="radio"/> WI <input type="radio"/> EI <input type="radio"/> LTD <input type="radio"/> Life Waiver of Premium	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> No
	<input type="radio"/> Workplace safety benefits <input type="radio"/> WI <input type="radio"/> EI <input type="radio"/> LTD <input type="radio"/> Life Waiver of Premium	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> No
	<input type="radio"/> Workplace safety benefits <input type="radio"/> WI <input type="radio"/> EI <input type="radio"/> LTD <input type="radio"/> Life Waiver of Premium	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> No
	<input type="radio"/> Workplace safety benefits <input type="radio"/> WI <input type="radio"/> EI <input type="radio"/> LTD <input type="radio"/> Life Waiver of Premium	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> 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 enrollees 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.

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 <input type="radio"/> 24/24 (default) OR <input type="radio"/> 12/12 (Option for Groups of 50 or more CI Lives) OR <input type="radio"/> 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: <input type="radio"/> Traditional Critical Illness (TCI) (Complete Coverage – 31 conditions) OR <input type="radio"/> 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: <input type="radio"/> Traditional Critical Illness (TCI) (Complete Coverage – 31 conditions) OR <input type="radio"/> 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	<input type="radio"/> Calendar Year <input type="radio"/> Benefit Year
-----------------------	--

Termination Age*	60 to 85 years	_____
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*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	<input type="radio"/> None <input type="radio"/> 1 year <input type="radio"/> 2 years
--------------------------	---

Healthcare Pooling	Threshold is per Insured and must be the same for all classes
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Threshold	<input type="radio"/> \$10,000 (default) <input type="radio"/> \$15,000 <input type="radio"/> \$20,000 <input type="radio"/> \$25,000
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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.

Drugs

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 Plan
 (Actively Managed Drug Plan available to Policyowners in all regions of Canada, except Quebec.)

Drug Benefit Type	<input type="radio"/> Standard Drug Plan <input type="radio"/> Actively Managed Drug Plan
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Standard Drug Plan

Method of Claim Submission	Pay Direct Drug Card
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	Division: _____
--	------------------------

	Class: _____
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Drug Plan Type

Prescription By Law, OR	Brand (RXA), Generic (RXAG), Mandatory Generic Substitution (RXMG), Provincial Formulary (RXO)	_____
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Prescribed (Over the counter medication included)	Brand Name (RXB), Generic (RXBG)	_____
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Coinsurance

Flat, or	50% to 100% in 5% increments	_____
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Two Tier	50% to 100% in 5% increments	_____
	Generic/Brand Name, or Provincial Formulary/Non Provincial Formulary	_____

Graded	_____ % of first \$ _____, _____ %	_____
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28 Deductible		CLASS
Annual Single/Family, or	<input type="radio"/> \$0/\$0, <input type="radio"/> \$25/\$50, <input type="radio"/> \$50/\$100, or <input type="radio"/> Other (indicate amount)	_____
Per Prescription, or	<input type="radio"/> Dispensing Fee, or <input type="radio"/> \$0 to \$20 in \$0.50 increments (indicate amount)	_____
Dispensing Fee Maximum *not applicable to employees and/or eligible dependants residing in Quebec	<input type="radio"/> \$0 to \$20 in \$0.50 increments (indicate amount), or <input type="radio"/> 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 Plan (available to Policyowners in all regions, except Quebec)		
Actively Managed Plan Type	<input type="radio"/> Preferred Choice Actively Managed Drug Plan To receive the higher level of reimbursement for maintenance and specialty 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. <input type="radio"/> Exclusive Actively Managed Drug Plan For maintenance and specialty drugs to be covered by the drug plan, they must be purchased through the ESC Pharmacy. All other drugs, including maintenance and specialty drugs not available through the ESC Pharmacy, can be purchased through a retail pharmacy and they will be covered under the plan.	
Method of Claim Submission	Pay Direct Drug Card	
Drug Plan Type	<input type="radio"/> Mandatory Generic Substitution <input type="radio"/> Generic	
Preferred Choice Actively Managed Drug Plan		
Coinsurance		
Express Scripts Pharmacy - Maintenance and Specialty 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 Pharmacy - Maintenance and Specialty Drugs		
ESC Pharmacy/Retail Pharmacy	\$0/Dispensing Fee	
All Other Drugs		
Retail Pharmacy	\$0	
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 Plan		
Coinsurance		
Express Scripts Pharmacy - Maintenance and Specialty Drugs		
ESC Pharmacy/Retail Pharmacy	CLASS	
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 Pharmacy - Maintenance and Specialty Drugs		
ESC Pharmacy/Retail Pharmacy	\$0/Dispensing Fee	
All Other Drugs		
Retail Pharmacy	\$0	
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)	<input type="radio"/> 70% <input type="radio"/> 75% <input type="radio"/> 80%* <input type="radio"/> 90% <input type="radio"/> 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	<input type="radio"/> 70% <input type="radio"/> 75% <input type="radio"/> 80% <input type="radio"/> 90% <input type="radio"/> 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	<input type="radio"/> 70% <input type="radio"/> 75% <input type="radio"/> 80% <input type="radio"/> 90% <input type="radio"/> 100%	_____
Private (includes Semi-Private)	Yes or No	_____
Coinsurance	<input type="radio"/> 70% <input type="radio"/> 75% <input type="radio"/> 80% <input type="radio"/> 90% <input type="radio"/> 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		
<input type="radio"/> 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, Chiropracist

Bundle 3 - Acupuncture, Naturopath, Osteopath

Coinsurance (*default)	<input type="radio"/> 70% <input type="radio"/> 75% <input type="radio"/> 80%* <input type="radio"/> 90% <input type="radio"/> 100%			_____
Maximum basis (*default)	<input type="radio"/> Per Certificate* <input type="radio"/> Per Insured			_____
Annual Maximum, per bundle (*default) (**only available per certificate)	Bundle 1	Bundle 2	Bundle 3	_____
	a) <input type="radio"/> \$500*	\$300	\$200, OR	
	b) <input type="radio"/> \$750	\$500	\$300, OR	
	c) <input type="radio"/> \$1,000	\$750	\$500**	
Per visit Maximum	<input type="radio"/> Yes <input type="radio"/> No			_____
Per Visit Maximum Amount	<input type="radio"/> \$25 <input type="radio"/> \$35 <input type="radio"/> \$50 <input type="radio"/> \$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: <ul style="list-style-type: none"> • 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	<input type="radio"/> 60 days <input type="radio"/> 90 days <input type="radio"/> 120 days
<input type="radio"/> 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

Health Care Spending Account available ONLY to Incorporated Companies.

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	<input type="radio"/> Per Insured <input type="radio"/> Per Certificate	_____
Major Restorative	<input type="radio"/> Per Insured <input type="radio"/> Per Certificate	_____
Orthodontic	Per Insured	
Survivor Benefit	<input type="radio"/> None <input type="radio"/> 1 year <input type="radio"/> 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	_____
Maximum		
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	<input type="radio"/> General <input type="radio"/> Specialist	_____
Province	<input type="radio"/> Employee province of residence (default) or <input type="radio"/> 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	<input type="radio"/> Per Insured <input type="radio"/> Per Certificate		
Deductible	\$0		
Coinsurance	<input type="radio"/> 80% <input type="radio"/> 100%	_____	_____
Annual Combined Maximum	<input type="radio"/> \$750 <input type="radio"/> \$1,000 <input type="radio"/> \$1,500 <input type="radio"/> Other \$ _____ (\$500 to \$3,000 in increments of \$250)	_____	_____
Recall	<input type="radio"/> 6 months <input type="radio"/> 9 months <input type="radio"/> 12 months	_____	_____
Scaling Units	<input type="radio"/> 12 <input type="radio"/> 15 <input type="radio"/> Other _____ (6 to 16 in 1 unit increments)	_____	_____
Fee Guide	<input type="radio"/> Standard <input type="radio"/> Deluxe (additional 25%)	_____	_____
Year	<input type="radio"/> Current <input type="radio"/> Fixed (provide year)	_____	_____
Practitioner	General		
Province	<input type="radio"/> Employee Province of Residence <input type="radio"/> 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))

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.

