

MASTER APPLICATION FOR GROUP INSURANCE UNDER THE RWAM TRUST

RWAM INSURANCE
ADMINISTRATORS INC.



PLEASE PRINT AND COMPLETE EACH SECTION IN FULL
& ENSURE THAT BENEFITS SELECTED COINCIDE WITH THOSE ON QUOTATION

1. APPLICANT

Full Legal Name _____		Operating Name (if a corporation) _____	
No. and Street _____		E-mail _____	
City, Province _____	Postal Code _____	Telephone _____	
Contact Person _____		Fax _____	
Nature of Business (describe fully) _____		<input type="radio"/> Unionized	<input type="radio"/> Proprietorship
_____		<input type="radio"/> Corporation	<input type="radio"/> Other (detail below)
_____		<input type="radio"/> Partnership	_____
Affiliates and Subsidiaries (print names in full) _____			

2. PRESENT COVERAGE

Will the insurance applied for replace similar insurance coverage? No Yes – If 'Yes', complete the following:

Name of Carrier(s) _____ Date Present Coverage is to be Terminated – detail if dates differ for each applicable benefit _____

Does your present benefit plan include?: Life and A.D.&D. Long Term Disability Extended Health Care Weekly Income Dental

3. POLICY EFFECTIVE DATE **Rates are effective for 15 months unless alternate arrangements have been approved.**

_____ Day Month Year

To avoid a period without coverage, do not terminate any existing coverage until notice has been given that RWAM Insurance Administrators Inc. has approved the coverage being applied for.

4. WAITING PERIOD **Length of time Employees must be employed in order to be eligible for coverage**

New employees (employed after the effective date) are eligible after _____ days of continuous full-time employment.
All present employees working full-time (at least 24 hours/week) are covered on the effective date, unless stated otherwise.

5. COVERAGE

If group is under 10 lives: All employees must apply for/participate in all benefits. If this condition is not met, insurance is subject to termination upon written notice by RWAM Insurance Administrators Inc.

If group is 10 lives or more: 75% participation must be maintained to continue coverage.

Contributory Participation is: Compulsory Voluntary
Employer contribution must be at least 50% of total premium

Non-Contributory Company pays 100% of the premium and 100% participation is required.
Life Insurance/Dependent Life Insurance premiums will be a taxable benefit and disability benefits will be subject to taxation.

Employee Claim Cheques
Send to: Employer Employee's Home Address – ensure that address information is on the Enrolment Form
 Electronic Fund Transfer (EHC & Dental Claims only) – ensure that each employee completes an EFT Authorization Form

6. ELIGIBLE EMPLOYEES **All permanent Employees working at least 24 hours/week** Other _____

Number of eligible full-time Employees _____ Do you currently employ contract employees?: Yes No

Number of Employees to be insured _____ If 'Yes', How are they remunerated? _____

Classes to be excluded _____ What is the length of the contract? _____

Coverage is subject to approval by RWAM Insurance Administrators Inc.



7. EMPLOYEES NOT ACTIVELY AT WORK

The undersigned applicant understands and agrees that this application applies solely to actively working employees and their eligible dependents who are not hospitalized on the applicant's effective date. For those employees not Actively at Work on the effective date, this application and certain benefits for them and their eligible dependents may be ineligible under group policy contract provisions until their return to Active Work.

The applicant declares: All employees are Actively at Work on the effective date
 The list of employees below are not Actively at Work on the effective date

Name	Reason not Actively at Work (ie. layoff, maternity or other leave, sickness, accident, disability)	Date Last Worked	Expected Return Date	If Claim is due to LTD, Auto, or WCB/WSIB, is it...		If Life Waiver is due to LTD, Auto, or WCB/WSIB, is it...	
				Approved	Pending*	Approved	Pending*

* If status is pending, provide details. If RWAM has been advised of these absences, please ensure that an enrolment form is completed for employees not actively at work – indicating those benefits that they wish to apply for. If RWAM has not been notified of these absences, RWAM reserves the right to decline coverage.

Is anyone currently on Spousal Survivor Benefits? Yes No

8. W.C.B./W.S.I.B.

Are all employees covered by W.C.B./W.S.I.B.? Yes No

If no was indicated above, list the full names of Employees who are **NOT** covered by W.C.B./W.S.I.B. (attach list if additional space is needed)

9. DESCRIPTION OF ELIGIBLE DIVISION(S)/CLASS(ES)

Division (1,2,3)	Description of Division – <i>separate billings will be issued</i>

Class (A,B,C)	Description of Class – <i>separate benefit plan design</i>

DESCRIPTION OF BENEFITS - If alternate plan designs/rates apply to different classes, please detail in the comments/rates section

10. EMPLOYEE LIFE INSURANCE - m YES m NO

Class	Benefit Schedule	Maximum Benefit
A		
B		
C		
D		
Non-Evidence Maximum		
Insurance Reduction (Age/Amt.)	50% at age 65 <input type="radio"/> Other _____	
Termination Age	70 <input type="radio"/> Other _____	
Rounding (If based on earnings)	To next higher \$1,000	

RATE
\$ _____ / \$1,000

11. DEPENDENT LIFE INSURANCE - m YES m NO

Volume: Spouse \$2,000 / Child \$1,000 Spouse \$10,000 / Child \$5,000
 Spouse \$5,000 / Child \$2,500 Spouse \$20,000 / Child \$10,000

RATE
\$ _____

12. EMPLOYEE ACCIDENTAL DEATH, DISEASE & DISMEMBERMENT (A.D.D.&D.) - m YES m NO

Volume: Equal to Life Volume 2 times Life Volume

Includes Critical Disease & Dismemberment Benefit

RATE
\$ _____ / \$1,000



13. EMPLOYEE WEEKLY INDEMNITY INSURANCE - m YES m NO

Benefit Commences: _____ Day for Accident _____ Day for Illness _____ Day for Hospitalization

Benefit Duration: _____ Weeks Taxable Non-Taxable (Employee must pay 100% of W.I. premium and applicable taxes)

Class	Benefit Percentage	Maximum Benefit
A		
B		
C		
D		
Termination Age	65	
Rounding	To next higher \$1.00	

Comments: _____

<p>RATE</p> <p>\$ _____ /\$10</p>

14. EMPLOYEE LONG TERM DISABILITY INSURANCE (L.T.D.) - m YES m NO

Compensation Method: Are any members of the plan compensated through Bonus, Dividends* and/or commissions? No Yes, attach details
* Bonus/Dividend income is not eligible for L.T.D.

Elimination Period: 17 weeks 26 weeks Other - _____ weeks

Maximum Benefit Period: 2 years 5 years to age 65

Coverage Details: 2 yr. Own-Occupation 1 yr. Own-Occupation Any Occupation Other _____

PosAbilities® / Monthly Transitional Benefit - includes Mandatory Early Intervention Program
Only available with 1 or 2 year Own-Occupation - ensure that this feature was included on original quotation

Obligations: If an employee stops working due to illness or injury for more than 2 weeks, the employer is obligated to send written notice immediately to RWAM/RWAM Disability Management, using the Notification of Absence Form.
It is a requirement under this plan that an employee participate in the Early Intervention Program.

C.O.L.A. _____% Without C.O.L.A. Contribution to Pension _____%

Taxable Non-Taxable (Employee must pay 100% of L.T.D. premium and applicable taxes)

Primary Offsets apply: CPP/QPP & WCB/WSIB (excluding benefit for dependent children)

Monthly Income	Class A		Class B		Class C		Class D	
Flat Rate Benefit %								
Graded Benefit	%	\$	%	\$	%	\$	%	\$
Benefit % on first \$ /monthly income								
Benefit % on next \$ /monthly income								
Benefit % thereafter								
Maximum Benefit								
Non-Evidence Max.								
Termination Age			65					
Rounding			To next highest \$1.00					

<p>RATE</p> <p>\$ _____ /\$100</p>



15. EXTENDED HEALTH CARE INSURANCE - m YES m NO

Classes Eligible _____ Termination Age _____

- PREMIUM FUNDING ARRANGEMENTS:
 Fully Insured
 Profit Participation - complete Profit Participation Application -Minimum 75 lives and \$75,000 combined EHC & Dental Premium
 A.S.O. Administrative Services Only * Min. \$10,000 ASO Premium
 H.S.A. Health Spending Account* Min. 10 lives if combined with an insured plan or 25 lives as stand-alone
* Please complete ASO/HSA checklist as part of the Master Application

DEDUCTIBLE:

- All Classes/ Class _____ Single \$ _____ Family \$ _____
 Class _____ Single \$ _____ Family \$ _____

CO-INSURANCE:

- All Classes/Class _____ Drugs _____% All other eligible expenses _____%
 Class _____ Drugs _____% All other eligible expenses _____%

Deductible and Co-insurance does not apply to Out of Province/Country, in Province Hospital or Vision Care Coverage unless otherwise indicated.

DRUGS:

- Type: Legally Requiring a Prescription Prescribed
To include: Erectile Dysfunction No Yes, (50%, up to \$600 annual maximum) or other _____
Fertility No Yes, (50%, up to \$1,500 lifetime maximum) or other _____
Form of Payment: Pay Direct Generic Drug Card - complete section below Reimbursement Drugs
 All Classes / Class _____ Co-Pay: m 20% m \$10.00 m \$5.00 m \$2.00 m Other
 Dispensing Fee Cap: m \$ _____ m Deductible equals Dispensing Fee
 O.D.B. Formulary Generic Product Selection (Doctor substitutions are permitted) Mandatory Product Selection (no substitutions are permitted)
 Class _____ Co-Pay: m 20% m \$10.00 m \$5.00 m \$2.00 m Other
 Dispensing Fee Cap: m \$ _____ m Deductible equals Dispensing Fee
 O.D.B. Formulary Generic Product Selection (Doctor substitutions are permitted) Mandatory Product Selection (no substitutions are permitted)

MAXIMUMS: All are subject to the group's co-insurance and deductibles, unless otherwise noted

- Private Duty Nursing at \$10,000 per calendar year, \$25,000 lifetime max. Other, please detail _____
Paramedical at \$400 per calendar year, per practitioner Other, please detail _____
Chiropractor/Podiatrist (insurance commences after provincial max. has been satisfied, unless otherwise noted)
 First dollar coverage to annual paramedical maximum
 \$20 per visit to annual paramedical maximum
 15 visit deductible followed by 100% coverage to annual paramedical maximum
Nutritional Counselling at \$150 per calendar year Other, please detail _____
Orthopedic Shoes at 50% - max. of 2 pair per calendar year and \$500 per calendar year Other, please detail _____
Orthotics - max. of 2 pair per calendar year and \$500 per calendar year Other, please detail _____
Hearing Aids at \$400 per 5 calendar years Other, please detail _____
Eye Examination YES One every 24 months / \$50 max. One every 24 months / reasonable and customary max.
 NO, remove this coverage
Stop Loss Pooling If less than 75 lives - \$5,000 If 75 lives or greater - Please select Nil \$10,000
Are there currently any insured members or dependents whose past year's health claims would have exceeded the stop loss pooling amount?
 Yes No

OUT OF PROVINCE/COUNTRY COVERAGE - 60 Days at 100% co-insurance/\$1,000,000 max. per calendar yr./\$50,000 Referral max. per calendar yr.

- Emergency & Referral Emergency Only

HOSPITAL: NO YES - m Semi-Private (includes convalescent care) m Private

VISION: NO YES - \$ _____ maximum every 24 months (adults and dependents)

COMMENTS:

RATES
ALL/CLASS _____
Single \$ _____
Family \$ _____
CLASS _____
Single \$ _____
Family \$ _____



16. DENTAL INSURANCE - m YES m NO

Classes Eligible _____ Termination Age _____

PREMIUM FUNDING ARRANGEMENTS:
 Fully Insured
 Profit Participation - complete Profit Participation Application - Minimum 75 lives and \$75,000 combined EHC & Dental Premium
 A.S.O. Administrative Services Only * Minimum 25 lives/\$25,000 ASO Premium
 H.S.A. Health Spending Account* Minimum 25 lives
* Please complete ASO/HSA checklist as part of the Master Application

DEDUCTIBLE:
 All Classes/ Class _____ Single \$ _____ Family \$ _____
 Class _____ Single \$ _____ Family \$ _____

SERVICES:
 All Classes/Class _____
 Basic, includes Endo., Perio., & Denture Repair/Reline & Rebase Co-Insurance _____% Maximum \$ _____
 Major Restorative Co-Insurance _____% Maximum \$ _____ or, Combined Annual Maximum of \$ _____
 Orthodontic - Age 17 and under Co-Insurance _____% \$1,500 Lifetime Maximum
 Class _____
 Basic, Includes Endo., Perio., & Denture Repair/Reline & Rebase Co-Insurance _____% Maximum \$ _____
 Major Restorative Co-Insurance _____% Maximum \$ _____ or, Combined Annual Maximum of \$ _____
 Orthodontic, - Age 17 and under Co-Insurance _____% \$1,500 Lifetime Maximum

RE-CALL: (exams, fluoride, prophylaxis, bitewing x-rays):
 6 months 9 months 12 months

FEE SCHEDULE:
 Current (Rates will be revised at renewal to reflect Fee Schedule changes)
 Other, as detailed _____

COMMENTS

RATES
ALL/CLASS _____
Single \$ _____
Family \$ _____
CLASS _____
Single \$ _____
Family \$ _____

17. SURVIVOR BENEFIT - m YES m NO

Applies only to groups participating in EHC and/or Dental

24 months Other - _____

NO CHARGE
FOR FULLY
INSURED

18. REQUEST FOR PRE-AUTHORIZED CHEQUE PLAN - m YES m NO

The P.A.C. withdrawal will be processed the first day of each month. THE FIRST MONTH'S PREMIUM AND A VOID CHEQUE ARE REQUIRED.

RWAM Insurance Administrators Inc. is authorized to draw cheques or issue directions each month for the purpose of paying premiums for the policy referred to herein. The policyholder hereby authorizes any banking institution with whom it has an account to deal with such cheques or directions as though they were authorized by itself.

Date Authorization Signature



19. APPLICATION TO PARTICIPATE IN THE RWAM TRUST

WHEREAS:

- (a) The Applicant desires to obtain the benefits requested in this Application for its eligible employees and their eligible dependents, and hereby applies to become a Participating Employer under the Retailers, Wholesalers and Manufacturers Group Insurance Trust (the "RWAM Trust");
- (b) The agreement governing the RWAM Trust (the "RWAM Trust Agreement") provides that the trustees of the said trust, or their authorized agents, shall have the right and discretion to accept or reject applications from qualified persons to become Participating Employers in the said trust from time to time;
- (c) Benefits provided by licensed insurers under group insurance contracts issued to the Trustees of the RWAM Trust (the "Trustees") include: Extended Health Care, Dental, Out-of-Province/Out-of-Canada coverage, group Life Insurance, Accidental Death, Disease & Dismemberment benefits, long term disability benefits or monthly transitional benefits, weekly indemnity benefits, and other optional group insurance products;
- (d) RWAM Insurance Administrators Inc. ("RWAM") is the authorized agent of the Trustees of the RWAM Trust, and has been appointed as administrator of the RWAM Trust.

NOW THEREFORE, subject to the Applicant being accepted as a Participating Employer in the RWAM Trust, THE APPLICANT ACKNOWLEDGES, UNDERTAKES AND AGREES:

1. To be bound by all the terms, provisions, conditions and limitations of the RWAM Trust Agreement and any and all insurance contracts issued to the Trustees and all lawful amendments thereto;
2. To pay, or cause to be paid, all contributions and premiums necessary to provide the benefits applied for herein, or subsequently requested, as and when required by the Trustees pursuant to the terms thereof;
3. That the only benefits provided shall be in accordance with this Application as submitted. Any changes desired by the Applicant must be requested in writing and are subject to the approval of the Trustees or their authorized agent, and shall only be effective as of the date of such approval.
4. To hold open for inspection any records in its possession or under its control relating to this Application and the benefits hereby applied for or provided hereunder, and to co-operate fully with the Trustees, RWAM and their agents in all matters regarding the benefits applied for or provided.
5. At all times, to enroll only actively working, eligible permanent employees and their eligible dependents for benefit coverage.
6. To immediately inform RWAM in writing of any changes to the Contributory or Non-Contributory status of its employees' premiums or contributions, including any changes affecting the status, for tax purposes, of any benefits provided for under this Application.
7. To provide immediate written notification to RWAM of any employee who ceases to be actively at work between the date this Application is signed and the date of acceptance of this Application.

The Applicant hereby appoints RWAM Insurance Administrators Inc. to act as its agent under the RWAM Trust Agreement, to act on the Applicant's behalf for the purposes of the said trust agreement, including, without limitation, any notice provisions or amendments thereto, save and except for any notice of default as to contributions or premiums, or any notice of termination as a Participating Employer.

The Applicant hereby declares that, to the best of the Applicant's knowledge, the statements and answers contained in this Application are full, complete and true as of the date hereof.

Subject to this Application being approved, the effective date of coverage in respect of the benefits hereby applied for shall be the Policy Effective Date indicated in this Application.

In the event any errors or omissions are discovered in this Application, RWAM is hereby authorized to amend this Application by noting the required change(s) on this Application. A copy of this amended Application shall be sent forthwith to the Applicant, and such action shall constitute acceptance of such change(s), unless the Applicant provides immediate written notice to the contrary.

An initial Premium Deposit of one month's premium is included with this Application.

Dated at _____ this _____ day of _____ 20____
(location) (day) (month) (year)

Applicant (Full Legal Name)

Signature and Title of Authorized Official

Witness

Agent

Agency