



APPLICATION FOR GROUP INSURANCE

Policy No. _____

1. **LEGAL NAME OF THE POLICYHOLDER** _____

Address of the Policyholder _____

Application is hereby made to Blue Cross of Atlantic Canada, operating under the business name "Atlantic Blue Cross Care" (hereinafter called Atlantic Blue Cross Care), and/or Blue Cross Life Insurance Company of Canada for Group Insurance in accordance with the specifications contained in this application. Health and/or Dental benefits are underwritten by Blue Cross of Atlantic Canada; all other benefits are underwritten by Blue Cross Life Insurance Company of Canada.

2. EFFECTIVE DATE

The Insurance will become effective at 12:01 a.m. local time on _____ year _____ provided that:

- (1) this application has been approved by Atlantic Blue Cross Care at its major location in Moncton, New Brunswick,
- (2) an amount approximately equal to one month's premium has been paid, and
- (3) in the case of contributory plans, at least _____ % of the eligible employees have applied for the coverage on the appropriate forms, or, in the case of non-contributory plans, 100% of the eligible employees have applied for the coverage on the appropriate forms.

3. FIRST RENEWAL DATE

The first renewal date will be 12:01 a.m. local time on _____ year _____

4. STATEMENT OF APPLICATION

All statements, representations and answers made in this application are a consideration for and a basis of the group policies between the policyholder and Atlantic Blue Cross Care and are declared to be true, full and complete.

It is understood and agreed that acceptance of any policies issued as a result of this application shall constitute approval of the provisions of the policies.

Signed for the Policyholder this _____ day of _____ year _____

at _____

Signature of Authorized Officer _____

Title _____

Signature of Witness _____

IMPORTANT: If you have a Group Insurance policy insuring any benefits for which you are now applying, **DO NOT CANCEL THE OTHER INSURANCE UNTIL THIS APPLICATION HAS BEEN APPROVED BY ATLANTIC BLUE CROSS CARE.**

GENERAL INFORMATION

5. POLICYHOLDER INFORMATION

- (a) The Policyholder is Incorporated Company Sole Proprietorship Partnership
 Other _____
- (b) Nature of Business (Explain Fully) _____
- (c) Subsidiary or Affiliated Companies to be insured.

_____	_____	_____	_____
Legal Name	Relationship	Location	Nature of Business

6. EMPLOYEE INFORMATION

- (a) All employees who are working for the Policyholder on a full-time permanent basis are eligible if they are working
 20 hours per week, or
 Other _____
- (b) Number of eligible employees _____
- (c) Number of employees enrolling in plan _____
- (d) Are any employees excluded from coverage? Please specify _____
- (e) Are union members to be covered under this plan? Yes No
- (f) Are all employees covered by Workers' Compensation? Yes No
 If no, state classes not covered _____

7. PLAN WAITING PERIOD

- (a) For the employees employed on the effective date the plan waiting period is Waived Not waived
- (b) The period of continuous full-time employment that an employee must work in order to be eligible for benefits is:
 _____ months, or
 _____ months; coverage is effective 1st of the month coincident with or next following this period, or
 Other _____

8. ACTIVELY AT WORK

- (a) Are any employees not actively at work due to accident or sickness on the date of this application? Yes No
 If yes, please provide full details below.

Name	Date of Birth	Last Day Worked	Reason for Absence

9. TRANSFER OF BUSINESS

- (a) Will any benefit under this policy for any class of employees replace or supplement similar benefits under another plan? Yes No
 If yes, give name of other carrier and details _____
- (b) Proposed date of cancellation of present plan _____
- (c) Will the previous carrier cover all the employees, listed under question 8 above, for any disability-related benefits? Yes No
 (If no, please explain in section 20.)

DESCRIPTION OF BENEFITS

16. HEALTH AND DENTAL COVERAGE

Enter Atlantic Blue Cross Care plan codes:

(Describe any non standard benefits in 20 below.)

Employee Class Code ●	Hospital	Travel	E.H.B.	Drugs		Dental
				Co-Pay	Ben. List	

17. OPTIONAL LIFE AND A.D. & D.

(a) Optional Life:

- Employee only
 Employee and eligible spouse

Units of _____ to a maximum of _____

(b) Optional A.D. & D.:

- Employee only
 Employee and eligible dependents

Units of _____ to a maximum of _____

18. TERMINATION AND COST SHARING OF BENEFITS

Benefit	Termination Age	Employee Contribution
Life/Dep. Life		
Critical Conditions	65	
A.D. & D.		
W.I.		
Long Term Disability	65	

Benefit	Termination Age	Employee Contribution
Health		
Travel		
Dental		
Optional Coverage	65	

19. COVERAGE CHANGE DATE

The date that the employee's insurance will commence or increase in response to a change in status is:

- the first of the month following the day on which the employee's status changes.
 the policy renewal following the day on which the employee's status changes.
 the actual date on which the employee's status changes.

20. ADDITIONAL COMMENTS AND SPECIAL INSTRUCTIONS

21. APPOINTMENT OF BROKER

_____ is appointed as broker of record for Group Insurance. The broker is authorized to act as our intermediary and to receive any fees and/or commissions payable by the insurer on the coverage provided under our group insurance policy.