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APPLICATION FOR GROUP INSURANCE

APPLICANT INFORMATION

Applicant (print full **legal** name of business as it should appear in the policy)

Mailing address: (in full)

Street City Province Postal Code

Business location:

Street City Province Postal Code

Legal Status: ❑ Corporation ❑ Partnership ❑ Sole proprietorship ❑ Trustee
❑ Union ❑ Association ❑ Other

Nature of business (goods or services provided):

How long has business been in operation?

Union ❑ Yes ❑ No Please attach a copy of the union contract or pages referring to group benefits.

Contact person name: Title:

Phone #: Fax #: E-mail address:

Print full names and addresses of any subsidiary or affiliated companies which are to be covered.

Subsidiary	Affiliated	Full names (as they should appear in the policy) and addresses of the companies
❑	❑	________________________________
❑	❑	________________________________
❑	❑	________________________________

Effective date requested:

1st day of ____________________, ________

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 Co-operators Life Insurance Company.

CURRENT COVERAGE

1. Will the insurance applied for replace similar insurance? ❑Yes ❑ No If YES, complete the following.
2. Is this group currently part of an association plan? ❑ Yes ❑ No If YES, name of assoc. ____________________________________ .
3. Copy of most recent billing (for grandfathering purposes) is attached? ❑ Yes ❑ No
4. Copy of current policy or booklet(s) are attached? ❑ Yes ❑ No
5. Information on any unique benefits, definitions, provisions, arrangements, etc. are attached? ❑ Yes ❑ No
6. Under Extended Health Care, is an individual stop loss or large amount pooling arrangement currently in place ? ❑ Yes ❑ No

   If yes, please answer the following:

   a. Please specify the stop loss/pooling structure and level(s).

   For example: Out-of-Country: 1st dollar, Drugs: $7,000 under 50 lives $14,000 over 50 lives, All other EHC claims(excluding vision care, out-of-country and drugs): $3,000 under 50 lives and $6,000 over 50 lives

   ____

   ____

   b. In the past 3 years, were there any claims that exceeded the stop loss/pooling level? ❑ Yes ❑ No

   If yes, please provide the amount(s) that exceeded the level and the renewal year(s) in which they were incurred:

Renewal Year	Amount exceeding the level
____________	____________
____________	____________
____________	____________

Benefit	Name of Current Carrier	Effective Date of Present Coverage	Number of Carriers in the Last 5 Years
Life	____________	____________	____________
AD&D	____________	____________	____________
Optional Life	____________	____________	____________
Optional AD&D	____________	____________	____________
Dependent Life	____________	____________	____________

Benefit	Name of Current Carrier	Effective Date of Present Coverage	Number of Carriers in the Last 5 Years
Weekly Indemnity	______	______	______
Long Term Disability	______	______	______
Extended Health Care	______	______	______
Dental Care	______	______	______

PREMIUM CONTRIBUTIONS

The employer will be paying the following percentage of premium for each benefit.

Life/AD&D ______ %

Dependent Life ______ %

Weekly Indemnity ______ %

Long Term Disability ______ %

Extended Health Care ______ %

Dental Care ______ %

ELIGIBILITY

Classes	# Employed	# Eligible	# Enrolling
❑ Permanent full-time	______	______	______
❑ Permanent part-time	______	______	______
❑ Union	______	______	______
❑ Non-Union	______	______	______
❑ Seasonal	______	______	______
❑ Contract	______	______	______
❑ Job Sharing Employees	______	______	______
❑ Extended Shift Hours	______	______	______
❑ Temporary Employees	______	______	______
❑ Independent Contractors	______	______	______
❑ Partners, Directors, Trustees and Shareholders	______	______	______
❑ Retirees	______	______	______
❑ Other: ______	______	______	______

Full-time individuals must work ______ hours per week.

Part-time individuals must work ______ hours per week.

Other individuals must work ______ .

New individuals under age 65 are eligible:

- ❑ On the first day of employment
- ❑ After having been employed for ______ days of continuous employment
- ❑ On the first of the month coincident with or next following ______ days of continuous employment

Present individuals are eligible:

- ❑ On the Policy Effective Date
- ❑ On the Policy Effective Date or after______ days of continuous employment, whichever is later.
- ❑ On the Policy Effective Date or on the first of the month coincident with or next following ______ days of continuous employment, whichever is later.

INDIVIDUAL INFORMATION

If **YES** is responded to any of the following questions, please provide details below or attach a separate page.
For questions 1 and 2, indicate the date of disability, age, sex, benefit amount, cause of disability and expected date of return to work. Please note that names need not be provided for questions 1 and 2.

	Question	Yes	No
1.	a) Are any individuals currently receiving disability benefits under a group plan, WCB or any other source?	❑	❑
	b) Has the current insurer waived the life insurance premium for these individuals?	❑	❑
2.	Any individuals currently absent from work due to sickness or injury?	❑	❑
3.	Has there been any significant change in the number of individuals in the past 3 years? If yes, why?	❑	❑
4.	Does the company receive any outside funding? If yes, from where and what percentage?	❑	❑
5.	Does the business operate from a location which is totally separate from the owner's residence?	❑	❑
6.	Are any Owners, Partners or other individuals not actively working at the business on a consistent basis?	❑	❑
7.	Please state name(s) of owner(s).	❑	❑

Are the owners being paid a salary? ❑ Yes ❑ No

If "No" provide details on how income is paid.

8. Please indicate the number of individuals enrolling by location:

Location	Number Enrolling	Location	Number Enrolling
______________________	__________	______________________	__________
______________________	__________	______________________	__________
______________________	__________	______________________	__________

Please state class and/or names for the following:

9. Any individuals NOT covered by Worker's Compensation.

10. Any individuals NOT covered by Employment Insurance.

11. Any individuals related to one another (ie. spouse, parent, child, sibling). State relationship.

12. Any individuals paid in full or in part by commissions.

13. Any individuals NOT being paid a salary or commissions. If yes, provide details on how income is paid.

ADMINISTRATION

1. **Billed** by Co-operators Life Insurance Company (The Co-operators)? ❑ Yes ❑ No
   The Co-operators Online Administration (Benefits Express)? ❑ Yes ❑ No
   Any special billing or other instructions? (eg. billings by account/class, use of employee number as PID numbers, etc....)

2. **Self-Reporting?** ❑ Yes ❑ No If using existing system, copy of current remittance report attached ❑ Yes ❑ No

   Please refer to The Co-operators Administration Manual for reporting requirements.

   The Co-operators Self-Reporting System (SRS) required? ❑ Yes ❑ No

3. **Claims verification** will be performed by: ❑ The Co-operators ❑ ________________________________
   Positive enrolment for EHC and/or Dental Claims verification? ❑ Yes ❑ No
   Note: Beneficiary designations are not accepted with Positive enrolment.

   The Co-operators Online Administration (Benefits Express)? ❑ Yes ❑ No

4. **Third party administrator**, if applicable: ____
   Full Name

   ____
   Address Postal Code

   Phone Number ____

   Fax Number ____

   Commission/admin. fee schedule attached. ❑ Yes ❑ No

5. **Claim Payments**
   Weekly Indemnity claims to be paid by: ❑ The Co-operators ❑ Other ______________________
   Extended Health Care claims to be paid by: ❑ The Co-operators ❑ Green Shield Pay Direct Drugs (attach application)
   ❑ Other ______________________
   Dental claims to be paid by: ❑ The Co-operators ❑ Green Shield Online Dental (attach application)
   ❑ Other ______________________

   Any unique handling of claim payments?

6. Are **booklets** to be issued by The Co-operators? ❑ Yes ❑ No If no, booklet must be approved by The Co-operators.
   Do you wish to receive them electronically? ❑ Yes❑ No Email Address: ________________________________
   Should TPA appear in booklet? ❑ Yes ❑ No

7. Development of special forms required? ❑ Yes ❑ No If yes, please explain.

8. Development of communication piece(s) required? ❑ Yes ❑ No If yes, please explain.

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APPLICATION/BENEFITS REQUESTED

Company name: ___________________________________ Class: _______________________________

COVERAGES

☒ GROUP LIFE COMMENTS:	❑ Salary related: ________ x annual salary to a maximum benefit of $______________ ❑ Flat benefit: $ ❑ Minimum amount under age 65 is $____________________. ❑ Reduce by 50% at age 65 to a maximum of $____________________. Terminates at age: ❑ 65 ❑ 70 Non-Evidence Maximum: $ ____________________
❑ OPTIONAL LIFE	Coverage can be taken in multiples of $10,000 to a maximum of $_______________/insured person. ❑ Employee ❑ Employee and spouse Terminates at age: ❑ 65 ❑ 70
❑ ADD&D	ACCIDENTAL DEATH, DISEASE & DISMEMBERMENT Equal to life benefit. ❑ No Disease
❑ OPTIONAL AD&D	Units of $____________ to a maximum of $_______________ Terminates at age: ❑ 65 ❑ 70
❑ DEPENDENT LIFE	CHILDREN ARE COVERED FROM BIRTH. ❑ Spouse: $5,000 Child: 2,500 ❑ Spouse: $10,000 Child: 5,000 ❑ Spouse: $20,000 Child: 10,000 ❑ Spouse: $________ Child: ________ Prenatal coverage ❑ Yes ❑ No
❑ PAID UP CERTIFICATE	$_______________ Minimum number of years of service _________ Not available prior to age ________
❑ WEEKLY INDEMNITY COMMENTS:	Benefit amount: ❑ ________% of weekly salary ❑ Flat $ ________________ ❑ ________% of first $____________ of weekly salary, ________% of next $____________ of weekly salary, ________% of balance Maximum benefit: $ ________________ or EI maximum (whichever is less) Type of plan: ❑ Taxable ❑ Non-taxable To obtain a non-taxable WI plan the employee must pay 100% of the WI premium. Benefits Begin: Hospital: ❑ 1st full day (minimum 24 hours) ❑ beginning 1st day(available to 10 lives plus) Accident: ❑ 1st day ❑ 8th day ❑ 15th day ❑ ____________ day Sickness: ❑ 1st day ❑ 8th day ❑ 15th day ❑ ____________ day Definition of disability: Own occupation Duration: ❑ 15 wks ❑ 17 wks ❑ 26 wks ❑ 52 wks ❑ Other _______________________ Terminates at age: ❑ 65 ❑ 70 CPP/QPP offsets: ❑ Primary ❑ Full
❑ LONG TERM DISABILITY COMMENTS:	Benefit amount: ❑ ___________ % of monthly salary ❑ Flat $ _____________ ❑ ___________ % of first $_______________ of monthly salary, ___________ % of next $_______________ of monthly salary,__________% of balance Maximum benefit: $ __________________ Non-evidence max.:$ __________________ Type of plan: ❑ Taxable ❑ Non-taxable To obtain a non-taxable LTD plan the employee must pay 100% of the LTD premium. COLA % ______________ CTP% ________________ CTP maximum $________ Elimination period: ❑ 90 days ❑ 105 days (15 weeks) ❑ 119 days (17 weeks) ❑ 182 days (26 weeks) ❑ 364 days (52 weeks) ❑ Other ____ **Note:** Elimination periods should coincide with weekly indemnity duration if weekly indemnity is quoted also. Duration: ❑ 1 year ❑ 2 years ❑ 5 years ❑ to age 65 From: ❑ Date of Disability ❑ End of the elimination period Terminates: At age 65 CPP/QPP offsets: ❑ Primary ❑ Full Definition of disability: ❑ 2 year own occupation, from the end of the elimination period, thereafter any and all ❑ Any occupation ❑ 2 year own occupation, from date of disability, thereafter any and all Partial Disability ❑ No ❑ Yes Survivor Benefit: ❑1 ❑2 ❑3 times monthly LTD benefit Pre-existing condition exclusion included: (Groups under 50 lives must have this provision included.) ❑ No ❑ Yes If yes: ❑ Standard ❑ Other ____________________________________
❑ BEST DOCTORS	Minimum of 25 individuals in all participating classification(s) combined.

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APPLICATION/BENEFITS REQUESTED

❑ POSACTION 500(EAP)	Please complete Form GL2078.
❑ EXTENDED HEALTH CARE COMMENTS:	CO-INSURANCE: Drugs _______________% All Other Expenses ______________%
	Deductible: ❑ Nil ❑ $_________/single $_________/family Emergency out-of-Canada expenses are covered at 100% co-insurance with no deductible. ❑ Travel Benefits Plus
	❑ **Vision Care:** ❑ $100/24 months ❑ $150/24 months *Note: 100% co-insurance, nil deductible* ❑ $200/24 months ❑ $________/24 months ❑ Coverage for children every 12 months (standard is 24 months)
	Hospital expenses: ❑ Semi-private room ❑ Private room *Hospital expenses are covered at 100% co-insurance with no deductible*
	Prescription Drug expenses: ❑ Reimbursement plan ❑ Pay Direct Drug plan: co-payment $ _________ per Rx or co-insurance _______ %
	Survivorship benefit: ❑ 2 years ❑ 5 years
	Terminates at age: ❑ 65 ❑ 70 ❑ __________ | Waive deductible ❑ Yes ❑ No (Inception year only)
❑ HEALTH SPENDING ACCOUNT	Please complete form GL2128.

❑ DENTAL COMMENTS:		COVERAGES	CO-INSURANCE	MAXIMUMS	
	Level 1	Basic services	_______________ %	Level 1	$ _____________ /year
	Level 2	Endodontic & periodontic	_______________ %	Level 2	$ _____________ /year
	Level 3	Major restorative	_______________ %	Level 1 & 2 combined	$ _____________ /year
	Level 4	Orthodontic	_______________ %	Level 1, 2 & 3 combined	$ _____________ /year
				Level 3	$ _____________ /year
				Level 4	$ ____________ /lifetime

Deductibles: ❑ Nil ❑ $__________/single $__________/family

Fee guide year: ❑ ____________________ ❑ Current fee guide
Specialists Fees: ❑ (General Practitioner Fees are standard)

Survivorship benefit: ❑ 2 years ❑ 5 years | ❑ Online Dental

Terminates at age: ❑ 65 ❑ 70 ❑ ________ | Waive deductible ❑ Yes ❑ No (Inception year only)

EXISTING PLAN PROFILE

Current coverages and rates

Life		AD&D		WI		LTD	
❑ Class 1	/$1,000	❑ Class 1	/$1000	❑ Class 1	/$10	❑ Class 1	/$100
❑ Class 2	/$1,000	❑ Class 2	/$1000	❑ Class 2	/$10	❑ Class 2	/$100
❑ Class 3	/$1,000	❑ Class 3	/$1000	❑ Class 3	/$10	❑ Class 3	/$100

EHC		Dental		Dep. Life		
❑Class 1	/employee /family	❑Class 1	/employee /family	❑Class 1	/employee	Waiting period:
❑Class 2	/employee /family	❑Class 2	/employee /family	❑Class 2	/employee	Effective date of current rates:
❑Class 3	/employee /family	❑Class 3	/employee /family	❑Class 3	/employee	

Other:

APPLICANT'S DECLARATION

The applicant hereby declares that, to the best of the applicant's knowledge, the statements and answers contained herein are full, complete and true as of the date hereof and expressly agrees and acknowledges that: (1) such statements and answers will be relied on by Co-operators Life Insurance Company, if it issues a group policy; (2) the insurance under the group policy shall become effective in accordance with and subject to the terms of the policy issued to the applicant; (3) in no case shall coverage become effective until this application has been approved in writing by Co-operators Life Insurance Company; and (4) Co-operators Life Insurance Company will not be liable to the applicant or to any of the applicant's employees or any other persons proposed to be covered under this application until it has been approved in writing.

An initial premium deposit of $ _________________ is included with this application. This cheque will not, of itself, constitute approval of the application. The cheque will not be deposited by Co-operators Life Insurance Company until the application is approved.

In the case of apparent errors and omissions discovered by Co-operators Life Insurance Company in this Application for Group Insurance, Co-operators Life Insurance Company is hereby authorized to amend this Application for Group Insurance by noting the change(s) in the section below. Acceptance of a copy of this Application for Group Insurance so amended shall constitute a ratification of such corrections or amendments.

Dated at ___________________________________ this _______________ day of ________________________, __________ .

by ____ (Applicant's signature)

______________________________________ (Title)

____ (Applicant's Printed Name)

PRODUCER'S DECLARATION

Agent/Broker Name	Address Street City Prov. Postal Code	
Phone #	Fax #	E-mail Address
SR4 Agent #	Commission Schedule attached. ❑ Yes ❑ No	License attached (if not already submitted): ❑ Yes ❑ No Note: A renewed license must be submitted upon expiry.

Comments:

I have advised the applicant: (1) not to terminate any existing coverage until notice has been received in writing that the coverage being applied for is accepted; and (2) no coverage is in existence until this application is approved in writing by Co-operators Life Insurance Company.

By: ____ Date: ______________________________________

CORRECTIONS/AMENDMENTS FOR THE CO-OPERATORS USE ONLY