MASTER APPLICATION FOR GROUP BENEFITS

APPLICANT INFORMATION

Plan Effective Date:			
Full Legal Name of Applicant:		Nature of Business:	
Principal Address:			Length of Time in Business:
City:	Province:		Postal Code:
Phone Number:	Fax Number:	Web Site Address	

CORRESPONDENCE & SIGNING AUTHORITY

Key Contact Name:	Title:	
Phone Number:	Fax Number:	Email Address:
Plan Administrator's Name:	Title:	
Phone Number:	Fax Number:	Email Address:

SUBSIDIARY, ASSOCIATED OR RELATED COMPANIES TO BE INSURED

(If more space is necessary, please attach a separate listing)

Company Name:	Contact Name:
Address:	
Company Name:	Contact Name:
Address:	

BILLING DIVISION STRUCTURE / INFORMATION

(If more space is necessary, please attach a separate listing)

Division	Division Name	Division – Nature of Business

PARTICIPATION

Number of Participating Employees:	Number of Eligible Employees:	Participation Percentage:

ELIGIBLE CLASSES

Class 1 Name:	Class 2 Name:	Class 3 Name:

EMPLOYEE ELIGIBILITY

	Class 1	Class 2	Class 3
Minimum No. of Hours Worked Per Week for Permanent Full Time Employees to be Eligible for Group Benefits must be 24 hours or more:			
Waiting Period for New Employees Hired After the Effective Date of Policy:			
Waive Waiting Period for Existing Employees Who Are Currently in Their Waiting Period Prior to the Effective Date of Policy?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
Are Overtime Earnings (earned on a regular basis) to be Covered Within Annual Earnings?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
Are Bonus Earnings (earned on a regular basis) to be Covered Within Annual Earnings?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
Are Seasonal Employees* to be Insured for Coverage Under This Plan?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
Are Independent Contractors* to be Insured for Coverage Under This Plan?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
Are All Participants Who Are Eligible for STD & LTD Covered by a Worker's Compensation or a similar plan?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No

* Seasonal Employees: Hired on a seasonal basis and has worked at least six (6) full months over the last twelve (12) month period.

* Independent Contractors: Hired on a contract basis for a minimum work term of six (6) continuous months.

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EMPLOYER / EMPLOYEE PREMIUM CONTRIBUTION SPLIT

Options	Class 1		Class 2		Class 3	
Overall Premium Sharing:	Employer Portion: _____%	Employee Portion: _____%	Employer Portion: _____%	Employee Portion: _____%	Employer Portion: _____%	Employee Portion: _____%
Short Term Disability (STD) Benefit:	❑ Taxable ❑ Non-Taxable	❑ Taxable ❑ Non-Taxable	❑ Taxable ❑ Non-Taxable	❑ Taxable ❑ Non-Taxable	❑ Taxable ❑ Non-Taxable	❑ Taxable ❑ Non-Taxable
Long Term Disability (LTD) Benefit:	❑ Taxable ❑ Non-Taxable	❑ Taxable ❑ Non-Taxable	❑ Taxable ❑ Non-Taxable	❑ Taxable ❑ Non-Taxable	❑ Taxable ❑ Non-Taxable	❑ Taxable ❑ Non-Taxable
Other Premium Sharing: Please provide details.						

In order for STD, LTD, and CI benefits to be received by the employee on a non-taxable basis, all employees in the class must pay 100% of the premium for these benefits. For non-taxable plans, the Employee's portion of the premium sharing will be applied firstly to 100% of the STD and LTD benefits (as applicable).

Are all employees actively at work on the effective date of the plan, or on the date of this application if earlier? ❑ Yes ❑ No

If No, please provide a list below of those employees who are not actively at work.

Employee	Occupation	Date of Last Day Worked	Nature of Absence	Expected Date of Return to Work

Will any of the benefits under this application replace similar benefits under another plan? ❑ Yes ❑ No

If Yes, please provide the following information for each insurer/benefit provider.

Name(s) of Insurer(s)	Policy No(s)	Termination Date(s)	Check Benefits with Previous Insurer(s)
			❑ Life ❑ AD&D ❑ Dep. Life ❑ STD ❑ LTD ❑ EHC ❑ Dental ❑ CI ❑ Optional Life ❑ Optional AD&D ❑ Optional CI ❑ Other (*please list*): _____

PRE-AUTHORIZED DEBIT AGREEMENT AUTHORIZATION

(Please attach a sample of your cheque from your Financial Institution marked "VOID")

Branch Transit Number	Institution	Account Number

Name of Financial Institution	Branch	
Branch Address	City, Province	Postal Code

The Applicant issues this authorization for a Pre-Authorized Debit to be taken monthly in variable amounts. The Applicant confirms whether this authorization is limited by a set maximum amount or no maximum amount.

❑ No Maximum Monthly Amount ❑ Maximum Monthly Amount of: $ _____ , _____ . ____

The Applicant may extend this authorization to include adjustments that would be processed subsequent to the monthly amount. In the event that Unistar Special Risks Inc. submits pre-authorized debits for adjustment amounts, the Applicant would be notified in writing of any such adjustments, including the reason for any such adjustment, within 48 hours.

❑ Adjustments Allowed ❑ No Adjustments Allowed

I hereby authorize Canadian Benefit Administrators Ltd. to make automatic withdrawals for my insurance premiums, from my account at the financial institution named below. I understand that the premiums will be withdrawn on the first Thursday of each month. Further, I understand that Canadian Benefit Administrators Ltd. will terminate my pre-authorized payment plan if any withdrawal is reversed by my financial institution. This will authorize Canadian Benefit Administrators Ltd. to charge a fee for any pre-authorized payments not honoured by my financial institution. This agreement will remain in effect until Canadian Benefit Administrators Ltd. receives a written notice of cancellation from me, or until I submit a pre-authorized withdrawal form.

Full Legal Name of Applicant:

Name(s) and Title(s) of person(s) authorized to sign for the Applicant	Authorized Signature(s)	Date Signed

APPLICATION FOR GROUP BENEFITS – LEGAL AUTHORIZATION

The person(s) signing this application on behalf of the Applicant agree(s) that the statements recorded in this application are true and complete, to the best of their knowledge and belief, and along with the Master Application Benefit Schedule shall form the basis of the Group Benefits Contract. As required by the insurers, in order to bind the coverage as applied for, a deposit cheque in the amount indicated herein has been submitted with this application payable to Canadian Benefit Administrators Ltd. (the Third Party Plan Administrator) to be applied against the billed amount of the first monthly premium. (Does not apply if PAD Agreement has been selected and Authorized).

Name(s) and Title(s) of person(s) authorized to sign for the Applicant	Authorized Signature(s)	Date Signed
Name of Witness	Signature of Witness	Date Signed

AGENT OF RECORD AND CLIENT DECLARATION

As a licensed agent, I represent my client and in respect of this Application for Group Benefits, I am working for you. I recommend insurers based on their response to my request for quotations and their record of service with you and with other clients. Like all agents, my compensation is arranged between the insurance company and me and is an element of your rate calculation. Arrangements can vary depending upon the service you require. I have a duty to disclose any conflict of interest that might be created by any such additional compensation. I confirm that there is no conflict of interest and my recommendation is based on my analysis of needs.

The undersigned Agent of Record declares that this Master Application For Group Benefits, plus the Client Employee Benefits Proposal, shall form the MASTER APPLICATION for Group Benefits for the Client named herein, and accurately represents the plan details and unit rates presented to and purchased by the Client.

Agent of Record Name:	Client Name:
Agent of Record Signature:	Client Signature:
Date Signed:	Date Signed: