APPLICATION FOR GROUP STOP LOSS INSURANCE

1) EMPLOYER INFORMATION		
Company Name (Applicant):		
Address:		
City:	Province:	Postal Code:
Contact Name/Position:	Phone:	
Fax:	Email:	
Effective Date of Group Coverage:	Date of Renewal:	
Authorized Signature:		

2) BILLING INFORMATION (Complete if different from above)		
Company Name:		
Address:		
City:	Province:	Postal Code:
Contact Name/Position:		
Phone:	Fax:	Email:

3) BROKER / AGENCY INFORMATION		
Company Name:		
Address:		
City:	Province:	Postal Code:
Contact Name/Position:	Phone:	
Fax:	Email:	

4) AGENT DECLARATION	
I CERTIFY THAT THE INFORMATION ON THE FOLLOWING APPLICATION AND IN THIS REPORT IS TRUE AND COMPLETE.	
Authorized Signature:	Date (MM/DD/YYYY):

5) COVERAGE SELECTION AND PLAN CHOICE

Please indicate your coverage level:

All employees must complete a Group Enrollment Form.

A) MEDICAL/DENTAL CARE BENEFITS

- **seCUREme Stop Loss:** 100% Coverage - $100, 000 Annual Maximum
- **seCUREme Stop Loss:** 80% Coverage- $100,000 Annual Maximum
- **seCUREme Pharma Only Stop Loss:** 100% Coverage - $25,000 Annual Maximum
- **seCUREme Pharma Only Stop Loss:** 100% Coverage - $100,000 Annual Maximum

B) ATTACHMENT POINT

- $2,500
- $5,000
- $10,000

C) OPTIONAL ACCIDENTAL DEATH & DISMEMBERMENT BENEFITS

Maximum of 5 times basic annual salary, overall maximum $500,000.00 Please indicate benefit amount elected:_____CAD

D) OPTIONAL TEMPORARY TOTAL DISABILITY BENEFITS

Following a 90 day waiting period, benefit payable is 70% of basic weekly earnings to a maximum of $12,000 CAD Per month for 24 months. A Medical questionnaire for each employee must accompany this application if the TTD benefit has been selected.

Option 1: 90 day Elimination Period

E) OPTIONAL PERMANENT TOTAL DISABILITY BENEFITS

This benefit is available in multiples of annual salary up to a maximum of 5 times your annual salary subject to an overall
Limit of $1,000,000. A medical questionnaire for each employee must accompany this application if the

PTD benefit has been selected. Indicate salary multiple elected:

□ 1 X □ 2 X □ 3 X □ 4 X □ 5 X

6) ACTIVELY AT WORK

It is hereby warranted that all employees insured are in good health and are actively at work at the inception date of this Policy or on the day he is eligible to be included in the plan and must not have been absent for more than 10 days in the preceding three months.

If the employee does not satisfy this condition then cover will not be provided until:

a) The employee has returned to work and competed two months continuous and active service, or
b) The employee has completed a Proposal From, satisfactory to Underwriters, if he wishes to be included in the plan earlier.

Please note that if option b) is chosen then option a) may not be chosen.

Actively at work means that employees are not only present at their place of work on the prescribed day but are mentally and physically capable of carry out their normal regular duties associated with the job for which they are employed.

Authorized Signature:	Title:

7) BILLING INFORMATION

PREMIUM DEPOSIT:

$_____estimated monthly premium. A deposit equal to the estimated monthly premium must be submitted along with this application.

MONTHLY BILLING GUIDELINES:

Premiums are calculated for complete months only. Full first month's premium is required for effective dates beginning on the first of the month. No first month's premium is required for effective dates falling 3 days prior to month end.

☐ INITIAL

8) PRIVACY STATEMENT

1. Please **READ and INITIAL** in the boxes provided in both the **PRIVACY** and **AUTHORIZATION/DECLARATION** sections of this page.

2. **Your SIGNATURE is required at the bottom of the form**.

3. Should you have any questions regarding either of these statements, please contact Health Risk Services directly prior to submitting the application.

YOUR PRIVACY – Respecting and Protecting your Personal Information

At Health Risk Services we recognize and respect the importance of privacy. When you apply for coverage, we will establish a confidential file that is kept in the Health Risk Services Office. We limit access to information in your file to Health Risk Services staff who require it to perform their duties, to persons to whom you have granted access, and to persons authorized by law. We use this information to administer your benefits plan. To review the entire Health Risk Services Privacy Guidelines, visit the Health Risk website: www.healthrisk.ca – Privacy Guidelines.

☐ INITIAL

9) AUTHORIZATION AND DECLARATIONS

The Applicant hereby applies for group insurance for its eligible employees. As an authorized representative of the Applicant, I understand and accept that:

- Terms as presented are to be administered for a minimum policy term of twelve (12) months;
- Coverage for the employees in the plan is based on the information provided in this application form or amendments to this form which have been accepted in writing by the insurer;
- All premiums are due and payable monthly in advance upon receipt of an invoice which will reflect insurance in force. We understand that premiums are due within 30 days of the billing date and Health Risk Services reserves the right to cancel coverage should such a premium not be paid. Premiums will be due and payable for the entire period the coverage was in effect;
- Health Risk Services reserves the right to charge interest on delinquent accounts in excess of thirty (30) days. The monthly rate of interest shall be 2%;
- Premium rates will be subject to adjustment for all coverage on each plan anniversary date. A financial review will be provided annually 30 days prior to the end of the policy term;
- Quoted premium rates exclude country premium taxes. Premium taxes will be calculated and added to the quoted premium rate at time of invoicing;
- I also give Health Risk Services permission to send communications pertaining to claims and the administration of the group benefits plan to the email I supply on this application form.

This Plan is underwritten by Anahita Insurance Corporation.

I/We hereby acknowledge that the statements contained herein are true and complete to the best of my knowledge together with any other forms signed by me/us in connection with this application form the basis for any policy issued hereunder. I/we understand and agree that coverage shall not become effective until final approval from the underwriter. I further agree to inform Health Risk Services of any changes to the information on this form. I accept the terms and conditions of participation as described above.

By signing this application, the Applicant/Policyholder confirms that the authorized members of the organization are able to confirm the existence and identity of each employee/member offered insurance under this program.

The information you provide will form part of the terms of coverage under this program. It will be used exclusively for the provision and administration of any health insurance, life and disability insurance and other related products and services.

I hereby understand that this policy will not come into effect until such time as the insurer or it's duly authorized representative has confirmed and communicated coverage to Health Risk Services and the appropriate premium for the coverage selected has been received.

☐ INITIAL

10)) SIGNATURE

I CERTIFY THAT ALL INFORMATION GIVEN IS TRUE, CORRECT AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

Authorized Signature:	Date Signed (MM/DD/YYYY):

seCUREme is a wholly owned division of Health Risk Services Inc.

seCUREme Stop Loss Insurance is underwritten by Anahita Insurance.

Secure and comprehensive insurance underwriters for corporate and personal products.

 # 50, 12221 – 44th Street SE | Calgary | Alberta | T2Z 4H3|info@healthrisk.ca