



P.O. Box 5044, 5420 North Service Road, Burlington, Ontario L7R 4C1 – 905.319.9501

Application for Group Insurance

In this Application, Provident Life and Accident Insurance Company is referred to as "the Insurer".

All questions **must** be answered in full (please print clearly)

1. NAME OF EMPLOYER: _____
(Full legal name)

2. ADDRESS: _____

City: _____ Province: _____ Postal Code: _____

3. LEGAL STATUS: Corporation Partnership Sole proprietor Other (specify): _____

4. NAME OF PLAN ADMINISTRATOR: _____

Tel: _____ Fax: _____ E-mail: _____

5. BILLING METHOD: Self-Administered List Bill T.P.A. (please complete a T.P.A. Questionnaire and Confirmation of Appointment of T.P.A. attach them to the Client Information Questionnaire)

6. SUBSIDIARY OR AFFILIATED FIRM TO BE INSURED (These will be shown in the contract): Subsidiary Affiliated
(NOTE: if more than two firms, please attach a separate list with all relevant information)

Full Legal Name _____ City and Province _____

No. of employees _____ Nature of business _____

SUBSIDIARY OR AFFILIATED FIRM TO BE INSURED: Subsidiary Affiliated

Full Legal Name _____ City and Province _____

No. of employees _____ Nature of business _____

7. WILL COVERAGE(S) APPLIED FOR REPLACE SIMILAR PRESENT COVERAGE(S)? Yes No

Name of Prior Insurer(s): _____ Date present coverage terminates: _____

Name of Prior Insurer(s): _____ Date present coverage terminates: _____

Coverages (if any) being replaced (for continuity purposes):	<input type="checkbox"/> Group Life	<input type="checkbox"/> Group Voluntary Life	
	<input type="checkbox"/> Group AD&D		<input type="checkbox"/> Employee Only
	<input type="checkbox"/> Group Dependent Life		<input type="checkbox"/> Employee and Spouse
	<input type="checkbox"/> Group STD		<input type="checkbox"/> Employee, Spouse & Children
	<input type="checkbox"/> Group LTD		

8. Please complete the following:

Applying to the Insurer for the following Insurance Coverages (attach the appropriate Appendices, which will form part of this Application for Insurance):	<input type="checkbox"/> Group Life	<input type="checkbox"/> Group Voluntary Life
	<input type="checkbox"/> Group AD&D	
	<input type="checkbox"/> Group Dependent Life	
	<input type="checkbox"/> Group Insured STD	
	<input type="checkbox"/> Group ASO STD	
	<input type="checkbox"/> Group LTD	

9. REQUESTED EFFECTIVE DATE: _____

10. ELIGIBILITY FOR INSURANCE:

NOTE: Eligible Employees will not include part-time, seasonal employees, employees hired on terms that their employment will end at a particular point in time, or independent contractors.

A person must be:

- (a) a "permanent" employee, partner or proprietor (hereinafter "employee"), and
- (b) actively at work and performing all the usual and customary duties of their regular occupations at least ____ hours per week (*note: 30 hours is standard*) (hereinafter "full-time").

Current number of eligible employees ____ .

Class Descriptions:

- Class 1: _____
- Class 2: _____
- Class 3: _____
- Class 4: _____
- Class 5: _____

11. PARTICIPATION: LTD benefits

- Mandatory (100% participation)
- Voluntary (minimum 75% participation)
- # eligible _____ # enrolled _____

All other benefits (except Group Voluntary Life)

- Mandatory (100% participation)
- Voluntary(*) (minimum 75% participation)
- # eligible _____ # enrolled _____

**If selected under this policy, Dependent Life, non-Voluntary Life and AD&D must be mandatory benefits.*

12. WAITING PERIOD:

A. **Current employees** are to be insured: (✓ one):

- On the policy effective date
- On completion of a total of _____ of continuous, active full-time employment
- On the first of the month coincident or next following _____ of continuous, active full-time employment

Does this apply to employees who have not completed the waiting period with the prior carrier? (✓ one):

- Yes – all current employees must satisfy any remainder of any longer waiting period with the Insurer.
- No – all such current employees will be covered on the policy effective date.

B. **Future employees** are eligible for insurance (✓ one):

- On date on which they begin active full-time employment
- On completion of _____ of continuous, active full-time employment as a permanent employee
- On the first of the month coincident or next following _____ of continuous, active full-time employment as a permanent employee

13. ARE THERE ANY ELIGIBLE EMPLOYEES NOT ACTIVELY AT WORK DUE TO MATERNITY/PARENTAL LEAVE, LAYOFF, OTHER APPROVED LEAVES OF ABSENCE, ILLNESS OR INJURY ON THE DATE OF THIS APPLICATION? Yes No

If yes, provide the details below attaching a separate list with all relevant information, if necessary.

Employee name	Age	Sex	Date disability or absence commenced	Nature of disability or absence	Prognosis	Expected date of return	Life waiver applied for and approved

14. BASIC EARNINGS (for purposes of determining amounts eligible as well as calculating benefit payments):

Options:

- Salary Only
- Salary and Commission
- Salary and Bonuses (please complete a Bonus Questionnaire and attach)
- Salary, Commissions and Bonuses (please complete a Bonus Questionnaire and attach)
- T-4 Employment Income
- T-5013 SUM/Partnership Schedule Summary (Calendar year or Tax year)
- T-1 Partnership Schedule (Calendar year or Tax year)
- Other**

Eligible Class

** If "Other," please specify: _____

NOTE: If bonuses and/or commissions are included, these amounts must be included in the earnings reported in the employee data.

APPLICANT'S STATEMENT

The Applicant hereby appoints _____ as Agent(s) of Record to act on behalf of the Applicant, and authorizes the Insurer to provide said Agent(s) with any information regarding this Application For Group Insurance and the Group Insurance Plan.

The Applicant hereby declares that all statements and answers made in this application (including any attached Appendices, census listings, etc.) are full, complete and true as of the date this application is signed and that he understands and agrees that:

1. This Application, including any Appendices, employee enrollment cards (if any), census listings (if any) and the data contained thereon, and any other documents required in order to be sufficient for purposes of applying for insurance, will form part of the relevant policy.
2. Coverage for any person will not commence or become effective unless and until he/she is a permanent employee actively at work full-time and performing all of his/her usual and customary duties.
3. Negotiation of the Premium Deposit cheque for the amount of \$_____ will not in itself constitute approval of this Application. If the Application is not approved, the amount received will be returned.
4. Coverage may be offered on terms other than as requested in this application, and any policy will include (and be subject to) all of its terms and conditions, which are not set out in full herein.
5. A copy of the Bonus Questionnaire is attached (if applicable). Yes No
6. The following Appendices are attached:
 - Group Life and Group AD&D Appendix
 - Group Short Term Disability Appendix
 - Group Long Term Disability Appendix
7. If any employees are resident in Ontario, the applicable Ontario Retail Sales Tax form is attached:
 - Ontario Retail Sales Tax Remittance Authorization Form
 - Ontario Retail Sales Tax Purchase Exemption Certificate

Signed at _____

This _____ day of _____, 20_____.

Name and Title of person authorized to sign from the Applicant
(i.e. Plan Administrator) (PLEASE PRINT)

Authorized Person's Signature

Signature of Witness if not signed under seal

PRODUCER/AGENT/BROKER'S INFORMATION

Corporate Name of Producer/Agent/Broker:

Address: _____

City: _____ Province: _____ Postal Code: _____

Tel: _____ Fax: _____

E-mail: _____

Is there currently a Producer Contract in place with the Insurer?

Yes No

Is this the first case with the Insurer?

Yes No

If "Yes", please expect to receive a Producer Contract for your completion.

The following materials are enclosed (✓) with this submission (if applicable):

- Premium Deposit for \$_____.
- Enrolment Cards (applicable if Life Benefit has been sold) from eligible employees to be covered. Total cards enclosed _____.
Number of cards still to be submitted: _____.
- Employee Census Data Listing (*Including Name, Occupation, Date of Birth, Province, Gender, Monthly Earnings, Date of Hire, Hours worked per week, and employee class if applicable*)
- TPA (Third Party Administration) Questionnaire (If applicable)
- Confirmation of Appointment of Third Party Administrator is attached (if applicable).
- Copy of the most recent billing from prior carrier (*Required only for previously insured groups*)
- Copy of the booklet wording from prior carrier (*Required only for previously insured groups*)
- Client Information Questionnaire

Date

Producer/Agent/Broker