Beneplan Inc

Mail to: 500-150 Ferrand Drive, Toronto, ON, M3C 3E5
Fax to: 416-863-5157

REIBA - Private Health Services Plan Application/Agreement

Between: Beneplan Inc.	And, Applicant's Name:

Employee

Employee's Full Legal Name: (*last, first, m.i.*)	❒ Proprietor ❒ Employee	Certificate/SIN # (optional)	
Street Address	City	Province	Postal Code
Telephone Number Residence: Work:	Occupation	Birth date (yyyy/mm/dd)	Gender ❒ Male ❒ Female
Name of Family Physician *(If none, list physician consulted in past 5 years)*	Address of Family Physician *(Number, street, City, Province, and Postal Code)*		

Spouse/Common Law Partner

Name of Spouse: (*last, first, m.i.*)	Birth date (yyyy/mm/dd)	Gender ❒ Male ❒ Female
Name of Spouse's Physician *(If none, list physician consulted in past 5 years)*	Address of your Spouse's Physician *(Number, street, City, Province, and Postal Code)*	

I HEREBY ELECT THE PLAN OPTION INDICATED BELOW

❒ **Core Group Health Insurance Plan**

and/or

❒ **Individual Health Spending Account:** Monthly funding of annual costs for eligible medical expenses not covered under the Core Group Health Insurance Plan.

Commencement of coverage is subject to acceptance and approval of attached Health Questionnaire by Beneplan.

Insures against catastrophic health expenses, i.e. semi-private hospitilzation, out-of-Province emergency coverage, nursing care, etc. It does not cover prescription drugs.

Select one of the following:

❒ SINGLE: $21/Month
❒ COUPLE: $35/Month
❒ FAMILY: $56/Month

Plus Retail Sales Tax (R.S.T.) where applicable.

Select the appropriate annual amount that would satisfy your dental, drug, vision, and other medical expenditure.

Option Chosen	Annual Amount	Monthly Premium
❒	$500	$46.90
❒	$1,000	$93.80
❒	$1,500	$140.70
❒	$2,000	$187.60
❒	$3,000	$281.40
❒	$5,000	$469.00
❒	$10,000	$938.00

Monthly Premium Payment			
	Core Group Health Insurance/Fee	Monthly Premium	$ ____________
	Individual Health Spending Account	Monthly Premium	$ ____________
		Total Monthly Premium	$ ____________

FAMILY COVERAGE: Complete this section if you elect family coverage.

First Name	Surname	Relationship	Birth date (yyyy/mm/dd)	Check if Dep. is a student under 25

If any of the above dependants are full time students, under age twenty-five (25) indicate the name of school/university being attended.

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Monthly premiums may vary annually upon at least thirty (30) days written notice from BENEPLAN. Individuals eligible for coverage under ProProtect's Private Health Services Plan may include; the Member, his/her spouse and dependants as well as employees of the Member and their respective spouses and dependants. Individual base Health Spending Account limits are as follows: Member/Employee: $1,500; Spouse: $1,500; Dependants: $750, unless specified employee participation levels are established.*

Premium Payment Pre-Authorization

The Member hereby agrees to pay monthly premiums in twelve (12) monthly payments of $___________, plus R.S.T., when applicable, on the first of each month commencing the first day of the month following acceptance of the application, and hereby authorizes his/her bank.

Financial Insitution	Address	Transit #:	Account #:

Please attach 'VOID' Cheque.

Cancellation and Health Spending Account Refunds

Core Group Health Insurance may be canceled on thirty (30) days written notice. Coverage will terminate upon cancellation or if premiums are unpaid, in accordance with Cooperators Life's policy terms.*

The Health Spending Account coverage may be canceled at any time on written notice and payment of any premiums required to cover drawn benefits. Coverage will terminate if premiums are unpaid for any month, unless outstanding balance and applicable service charges are paid in full. On termination, any balance in the account will be refunded solely to the Member and not to any Employee, in accordance with applicable Income Tax rules. Any deficit must be paid by a one-time premium adjustment.

Eligibility

Eligibility is restricted to residents of Canada. Spousal and family coverage limits, which differ for Core Group Insurance and Health Spending Account coverage, are described more fully in the "Plan Terms and Conditions booklet."*

Taxation Treatment

ProProtect is a "Private Health Services Plan" under sections 20.01 and 248(1) of the Income Tax Act (Canada). Tax deductibility of premiums for professionals and self-employed individuals and the effect on the Member's taxation* are subject to the above sections. **BENEPLAN/*ProProtect*** make no warranty or representation as to taxation consequences; which should be confirmed with the Member's own tax advisor.* A condition for the deductibility of premiums is that professionals and self-employed Members must extend benefits equivalent to those received by them to all their full-time, permanent, arms-length employees. Employees may be asked to participate in the cost of the plan and may waive participation.

Employee Enrollment

Members may add employees at any time and under conditions as established by the Member.

Acceptance

Your execution and submission to BENEPLAN of this application and agreement, together with a fully completed Cooperators Life health questionnaire, will, after review and upon acceptance by Cooperators Life for group health insurance coverage, constitute acceptance of the terms of ***ProProtect*** coverage as specified herein.

Date: ______________________ Member / Employee Signature: ______________________________

*See ProProtect "Plan Terms and Conditions booklet" available from BENEPLAN.

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Employee's Full Legal Name: (*last, first, m.i.*)	Certificate/SIN #:

Information regarding health of spouse and children is only required if applying for family coverage. All questions should be fully completed to avoid delays in the assessment. For all questions answered "Yes", use the details section on the opposite page to explain.	**Applicant**		**Spouse/Children**	
1 Have you ever been tested for or told that you had: a) Abnormal blood pressure, heart attack, Angina or any other disease or disorder of the heart or blood vessel?	**Yes**	**No**	**Yes**	**No**
b) Stomach trouble, including ulcers, hernia, gall bladder or other digestive disorders?	**Yes**	**No**	**Yes**	**No**
c) Venereal Disease, abnormal urine or any disease of the kidneys, bladder, prostate or reproductive organs?	**Yes**	**No**	**Yes**	**No**
d) Hepatitis, stroke, diabetes, pneumonia, mental illness, cancer, asthma?	**Yes**	**No**	**Yes**	**No**
2 Have you ever: a) Had or been diagnosed, received treatment or told that you have AIDS (Acquired Immune Deficiency Syndrome), HIV (Human Immune Deficiency Virus), ARC (Aids Related Complex) or any other immunological or disorder?	**Yes**	**No**	**Yes**	**No**
b) Had a positive test for, exposure to the AIDS Virus including each: HTLV III / LAV / HIV Antibody?	**Yes**	**No**	**Yes**	**No**
3 In the last five years, have you used, received treatment or counseling for narcotics, hallucinogenic, or other habit forming drugs or had been advised to reduce your intake or been treated for excessive use of alcohol?	**Yes**	**No**	**Yes**	**No**
4 Have you any impairment or condition for which medical treatment, hospitalization or surgery has been advised within the next year?	**Yes**	**No**	**Yes**	**No**
5 Have you taken any medication or been treated or told that you had any physical impairment, condition, disease or disorder, not stated in this questionnaire?	**Yes**	**No**	**Yes**	**No**
6 Have you ever had an application of insurance declined, postponed or rated? If yes, state insurance company and reason.	**Yes**	**No**	**Yes**	**No**

7 Applicant's height _________ ft/m _____ in/cm Applicant's weight ________ lbs/kg

Spouse's height __________ ft/m _____ in/cm Spouse's weight _________ lbs/kg

If there has been a weight loss or gain of more than 15lbs in the last twelve months, state reason for gain or loss.

The following questionnaire relates to question 1 above.

Blood Pressure

Date first advised blood pressure elevated	In the past two years have special tests been done? ❒ No ❒ Yes, indicate type of test, date(s) and results
Treatment ❒ Diet ❒ Medicine ❒ Other_______________	
How long on treatment? ___________________________	Are you aware of any recent readings? ❒ No ❒ Yes, give readings ___________________________
Are you still under treatment? ❒ Yes ❒ No Name and address of attending physician (if different from the front).	

Gastrointestinal Disorders

Type ❒ Ulcer ❒ Other, specify	Treatment ❒ Medicine, give name ___________________________ ❒ Operation date ___________________________
Date of first attack (d,m,y)	Do you now have symptoms (d,m,y)? ❒ Yes ❒ No
Date of last attack (d,m,y)	Are you still under treatment (d,m,y)? ❒ Yes ❒ No
No. of attacks	Name and address of attending physician (if different from the front).
Was there any vomiting of blood or passage of blood or tarry stools through the bowel? ❒ Yes ❒ No	

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Details

Use this section to fully explain all questions answered "Yes" to on the Health Questionnaire on the opposite page, except where a related questionnaire should be completed. Attach any additional information if more space is needed.

Question Number	Name and Relationship (Applicant / Spouse / Dependant)	Health Details	Date	Attending Physician's Name and Address

The undersigned have read the statement and understand the answers recorded in this application and any supplementary application. They are to the best of my / our knowledge and belief, true and complete and recorded correctly. I certify that I have a copy of this form (or have asked Cooperators Life for a copy) and I authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically -related facility, or insurance company, that has any medical records or medical knowledge of me or any of my dependants to give to The Cooperators Life Company or its reinsurers any and all such medical information.

I understand the information obtained by use of this authorization will be used by The Cooperators Life Company or its reinsurers to determine eligibility for group life and / or health insurance. I agree that this authorization should be valid for thirty (30) months from the date shown below and that a photocopy of this authorization shall be valid as the original.
I certify that I am actively at work on the date this application was signed.
.
I hereby authorize the use of my social insurance number for the administration of the benefits applied for under this group policy.

Date (d,m,y): _________________ Signature of Spouse (if applicable): ___________________________

Signature of Applicant: ____