



Benepac® Employer Application for Group Insurance

Name of Employer

Employer Information

Address		Postal Code	Phone	Fax
Web Site Address		Administrative Contact / E-mail Address		Executive Contact / E-mail Address
Nature of Business		Length of Time in Business	Subsidiaries or Affiliates to be Included	
Name of Sponsoring Association (if applicable)		Are all employees covered by WCB? Yes <input type="checkbox"/> No <input type="checkbox"/>		
Is the organization classified as Not-For-Profit? Yes <input type="checkbox"/> No <input type="checkbox"/>	Are any employees in Canada on a Work Visa/ Permit? Yes <input type="checkbox"/> No <input type="checkbox"/>	Are there any independent contractors to be included? Yes <input type="checkbox"/> No <input type="checkbox"/>	Plan Effective Date Requested	

Previous Insurance Coverage (if applicable)

Name(s) of Previous Insurer(s)	Policy Number(s)	Termination Date(s)	Check Benefits in Force with Previous Insurer(s) <input type="checkbox"/> Life <input type="checkbox"/> AD&D <input type="checkbox"/> Dep Life <input type="checkbox"/> STD <input type="checkbox"/> CI <input type="checkbox"/> LTD <input type="checkbox"/> EHC <input type="checkbox"/> Dental <input type="checkbox"/> Other _____
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Employee Eligibility / Waiting Period / Participation

Eligibility

- All employees who work for the employer for the minimum number of hours indicated, are eligible for coverage (**Minimum hours: 20/week**) _____ Hours per Week
- Number of employees eligible for this plan **1** _____ Employees

Waiting Period

- The Waiting Period is the number of continuous months of employment with the employer indicated (Approval required for less than 3 mos) _____ Months
- Does the waiting period apply to those employees employed prior to the Plan Effective Date? (check one) Yes No

Participation

- Is this plan Contributory or Non-Contributory? (check one) Contributory Non-Contributory
 Note: • Contributory plans are those where the employees are required to pay a portion of the total premium.
 • Non-contributory plans are those where the employer pays 100% of the premium.
- Participation percentage required under this plan _____ %
 Note: • 100% of eligible employees must participate for groups with less than 10 employees.
- Number of employees participating in this plan **2** _____ Employees
- Participation percentage for this plan **2 ÷ 1** _____ %

Premium Contributions (check benefits insured and indicate percentages paid by Employee and Employer)

Benefit (check if insured <input checked="" type="checkbox"/>)	Paid by Employee	Paid by Employer	Benefit (check if insured <input checked="" type="checkbox"/>)	Paid by Employee	Paid by Employer
<input type="checkbox"/> Life Insurance	_____ %	_____ %	<input type="checkbox"/> Critical Illness	_____ %	_____ %
<input type="checkbox"/> AD/D&D	_____ %	_____ %	<input type="checkbox"/> Extended Health Care	_____ %	_____ %
<input type="checkbox"/> Dependent Life Insurance	_____ %	_____ %	<input type="checkbox"/> Dental	_____ %	_____ %
<input type="checkbox"/> Short Term Disability	_____ %	_____ %	<input type="checkbox"/> Health Care Spending Account	_____ %	100 %
<input type="checkbox"/> Long Term Disability	_____ %	_____ %	<input type="checkbox"/> Employee Assistance Plan	_____ %	_____ %

Note: The Employer must pay at least 50% OF THE TOTAL PREMIUM for this plan – not necessarily 50% of the premium for each benefit. In order for Short Term Disability or Long Term Disability benefits to be received by the Employees on a Non-Taxable basis, all Employees must pay 100% of the premium for these benefits. Ontario Retail Sales Tax – The insurer(s) will remit the applicable sales tax due on behalf of the employer and the employee to the Government of Ontario. Amounts remitted will be in accordance with the current regulations under the Ontario Retail Sales Tax Act, and will apply for the duration of the contract.



Pre-Authorized Payment Plan

Customer Information

Company Name: _____

Company Address: _____ City: _____

Province: _____ Postal Code: _____ Phone: _____

Bank Account Information

Financial Institution (FI): _____

Branch Address: _____ City: _____

Province: _____ Postal Code: _____ Phone: _____

Account Number: _____ Transit Number: _____ Bank Number: _____

Pre-Authorized Debit Authorization

These services are for: Personal: _____ Business: _____

BBD is hereby authorized to process a debit, in paper, electronic or other form as follows:

- Variable amount: "\$X.xx" with "variable payment amount \$X.xx" being stated on a statement available to the company at www.bbd.ca at least 10 calendar days prior to the debit date. To obtain the ID code to access your statement, please contact your Account Manager.
- To be drawn on the above account on the 1st day of each month commencing _____

I (we) acknowledge that I (we) have read, understand, and agree to all the provisions contained in the terms and conditions of the Pre-Authorized Debit Plan and that I (we) have received a copy of such terms and conditions.

Authorized Signature _____ Date _____

Authorized Signature _____ Date _____

Please return completed form and void cheque to BBD:

Head Office

500 - 2755 Lougheed Highway
Port Coquitlam, BC V3B 5Y9

T: 604.464.0313 F: 604.464.7997 TF: 800.668.2295

Ontario Office

Suite 3 - 55 Rideau St.
Kingston, ON K7K 2Z8

T: 613.530.2422 F: 613.530.3770 TF: 888.272.0413

www.bbd.ca



Pre-Authorized Debit Plan Terms and Conditions

TO BE RETAINED BY PAYOR

"I (We) acknowledge that this Authorization is provided for the benefit of the Payee and The Royal Bank and is provided in consideration of The Royal Bank agreeing to process debits against my account in accordance with the Rules of the Canadian Payments Association."

"I (We) warrant and guarantee that all persons whose signatures are required to sign on this account have signed this agreement."

"I (We) hereby authorize BBD to draw on the Payor's account number according to the Pre-authorized Debit Authorization."

"This Authorization may be cancelled at any time upon notice by the Payor. I (We) acknowledge that, in order to revoke this Authorization, I (We) must provide notice or revocation to BBD 10 working days prior to the next due date of the Pre-Authorized Debit. I (We) may obtain a sample cancellation form, or more information on my (our) right to cancel a PAD Agreement at my (our) Financial institution or by visiting www.cdnpay.ca."

"I (We) acknowledge that provision and delivery of this Authorization to BBD constitutes delivery by the Payor to The Royal Bank. Any delivery of this Authorization to you constitutes delivery by the Payor."

"I (We) undertake to inform BBD, in writing, of any change in the account information provided in this Authorization 10 working days prior to the next due date of the Pre-Authorized Debit (PAD)."

"I (We) acknowledge that The Royal Bank is not required to verify that a PAD has been issued in accordance with the particulars of the Payor's Authorization including, but not limited to, the amount."

"I (We) acknowledge that The Royal Bank is not required to verify that any purpose of payment for which the PAD was issued has been fulfilled by BBD as a condition to honouring a PAD issued or caused to be issued by BBD on the Payor's account."

"Revocation of this Authorization does not terminate any contract for goods or services that exists between the Payor and BBD. The Payor's Authorization applies only to the method of payment and does not otherwise have any bearing on the contract for goods or services exchanged."

"I (We) have certain recourse rights if any debit does not comply with this agreement. For example, I (we) have the right to receive reimbursement for any debit that is not authorized or is not consistent with this PAD Agreement. To obtain more information on my (our) recourse rights, or obtain a form for a Reimbursement Claim, I (we) may contact my (our) financial institution or visit www.cdnpay.ca."

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