the co-operators®
A Better Place For You®

ASSOCIUM Benefits

GROUP BENEFITS
ASSOCIUM GROUP BENEFITS INSURANCE PROGRAM
PARTICIPATING EMPLOYER APPLICATION

To avoid delays, please complete the required information by printing clearly in ink.
Do not terminate any existing coverage until notice has been given in writing that the coverage being applied for is approved by Co-operators Life Insurance Company.

1. POLICYHOLDER INFORMATION

Policyholder **Associum Group Benefits Insurance Program** Group **6312**

2. PARTICIPATING EMPLOYER INFORMATION

Effective date requested: 1st day of Sep (MMM) , 20 12

Participating Employer _____

Mailing Address _____ (Street) _____ (City) _____ (Province) _____ (Postal Code)

Phone Number (_____) _____ Fax Number (_____) _____

Business Location _____ (Street) _____ (City) _____ (Province) _____ (Postal Code)

Nature of Business (goods or services provided) _____

Legal Status: ☐ Corporation ☐ Partnership ☐ Sole Proprietorship ☐ Trustee ☐ Association ☐ Other _____

Plan Administrator

Name _____

Job Title _____

Email _____

Is administration contracted to an outside source? ☐ Yes ☐ No

If yes, please complete information listed below:

Name of Company _____ Contact Person _____ (First Name) _____ (Last Name)

Email _____ Phone Number (_____) _____ Fax Number (_____) _____

Subsidiary	Affiliated	Please provide full legal names and addresses of any subsidiary and affiliated company that are to be included under this plan.
☐	☐	Legal Name _____ Address _____ (Street) _____ (City) _____ (Province) _____ (Postal Code)
☐	☐	Legal Name _____ Address _____ (Street) _____ (City) _____ (Province) _____ (Postal Code)

3. CURRENT COVERAGE

If this coverage replaces another policy, please indicate prior carrier, policy number and benefits covered: _____

If you respond YES to any of the following questions, please provide details below or attach a separate page.

Are any employees currently absent from work due to sickness, injury or any other leave? ☐ Yes ☐ No

If yes, complete the following:

First and last name	Last day worked	Reason for absence	Expected return to work date	Approved for Life Waiver
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

4. PREMIUM CONTRIBUTIONS

The employer will be paying the following percentage of premium for each benefit.

Basic Life	_____ %	Short Term Disability	_____ %	Critical Illness	_____ %	Dependant Life	_____ %
AD&D	_____ %	Long Term Disability	_____ %	Dental Care	_____ %	Extended Health Care	_____ %

5. ELIGIBILITY

Total Number of Plan Members _____ Number of Enrolled Plan Members _____

If the above numbers are different, please explain _____

☐ Permanent full-time employees must work a minimum of _____ hours per week

☐ Permanent part-time employees must work a minimum of _____ hours per week

☐ Other _____ Provide detailed eligibility requirements _____

(example: retirees, hourly, union or hour bank)

New employees are eligible:

☐ On the first day of employment

☐ After having been employed for _____ days of continuous employment

☐ On the first of the month coincident with or next following _____ days of continuous employment

Present employees are eligible:

☐ On the Policy Effective Date

☐ On the Policy Effective Date or after _____ days of continuous employment, whichever is later

☐ On the Policy Effective Date or on the first of the month coincident with or next following _____ days of continuous employment, whichever is later

6. ADMINISTRATION

☐ **SELF-ADMINISTERED**

7. PLAN MEMBER BOOKLET INFORMATION

Booklets are available in electronic and paper format. Select the format(s) required. ☐ Electronic ☐ Paper

8. POLICYHOLDER DECLARATION

The Participating Employer hereby declares that, to the best of the Participating Employer's knowledge, the statements and answers contained herein are full, complete and true as of the date hereof and expressly agrees and acknowledges that: (1) if Co-operators Life Insurance Company issues a group policy, it will rely on such statements and answers, (2) if Co-operators Life Insurance Company issues a group policy, coverage will be effective in accordance with the policy's terms and conditions, (3) coverage will not become effective unless Co-operators Life Insurance Company approves this application in writing, and (4) Co-operators Life Insurance Company cannot be liable to the participating employer, or to any of the participating employer's employees, or to any other persons for whom coverage is requested unless Co-operators Life Insurance Company approves this application in writing.

An initial premium deposit of $ _____ is included with this application. This cheque will not, of itself, constitute approval of the application. The cheque will not be deposited by Co-operators Life Insurance Company until the application is approved.

If Co-operators Life Insurance Company discovers any error or omission in this application, which appears to have been made advertently, it can amend the application by identifying the error or omission and by noting the change(s) in the section below. The policyholder agrees to Co-operators Life Insurance Company changes when it accepts a copy of the amended application.

We acknowledge and agree that the attached Schedule of Benefits forms part of the application and represents the coverage we requested from Co-operators Life Insurance Company.

Dated at this 31 day of Dec , 20 20

By _____ Job Title _____
(Participating Employer's Signature)

_____
(Participating Employer's Printed Name)

9. PRODUCER DECLARATION

Please indicate Commission Payee: ☐ Advisor ☐ Corporation ☐ SR4 Co-operators Agent

Existing Advisor Number _____ Payee Name _____ _____ _____
First Name Initial Last Name

Payee Address _____ _____ _____ _____
Street City Province Postal Code

Phone Number (_____)_____ Fax Number (_____)_____ Email _____

SIN Number* _____ Principal Name** _____
*Required only if Advisor **Required only if Corporation

9. PRODUCER DECLARATION (CONTINUED)

This section to be completed by individual advisors and corporations.
(Not applicable to SR4 Co-operators Agents)

Commissions are payable upon receipt and verification of the named active payee's license after premiums have been applied. A renewed license must be submitted to The Co-operators upon expiry:

☐ Payee License Attached
☐ Payee License Already Submitted

Please select ONE Commission Type:

☐ Payable
☐ Retained by TPA

Commissions are payable by direct deposit. A copy of the payee's cheque marked "VOID" must be attached to this sales submission. The banking information must be for the above named payee and licensee. If no cheque is included, please have the following Verification by Branch section below completed by the payee's financial institution.

VERIFICATION BY BRANCH

Branch Number (5 Digits) _____ Bank Number (3 Digits) _____

Account Number _____ Account Name _____

Signature of Branch _____ Job Title _____

Phone Number (_____)_____

9. PRIVACY & AUTHORIZATION

CO-OPERATORS LIFE INSURANCE COMPANY PRIVACY STATEMENT
Co-operators Life Insurance Company is committed to protecting the privacy, confidentiality, accuracy and security of the personal information that it collects, uses, retains and discloses in the course of conducting business.

I hereby authorize Co-operators Life Insurance Company to deposit commission payments directly to my account and to exchange my relevant financial information with my financial institution for such purpose. This authorization shall remain valid until revoked by me in writing. Any changes to the issued banking information must be made with three weeks notice to avoid any payment delays. Any copy of this authorization shall be as valid as the original.

I have advised the applicant (1) not to terminate any existing coverage until notice has been received in writing that the coverage being applied for is accepted, and (2) no coverage is in existence until the application is approved in writing by Co-operators Life Insurance Company.

By _____ Date _____
Producer Signature MMM/DD/YYYY

10. Appliction Declaration and Administrative Agreement

This agreement is between ASSOCIUM Benefits. And _____

ASSOCIUM Benefits agree as follows:

1.PURPOSE:

This is an employee group benefits plan administration agreement and Group Insurance Application. Its purpose is to provide for the establishment and administration of an Employee Benefit Plan for the Plan Sponsor.

Health and Dental Benefits: The Plan carriers will reimburse Eligible Participants for expenses incurred in the provision of Eligible Benefits to the annual maximum for each class of Benefits outlined in Schedule of Benefits, subject to applicable co-insurance requirements.

Life and Disability: The Plan carriers will reimburse Eligible Participants or their designated beneficiaries for claims made according to the terms of the policy and as outlined in Schedule of Benefits.

2. BENEFIT EFFECTIVE DATE:

- Coverage under this contract will commence for treatment rendered on and after the effective date of the plan.
- This contract shall be for an indefinite period and can be cancelled on thirty days' notice.
- Rates will be renewed annually. All plan members are renewed simultaneously.

3. FEES AND PAYMENT OF FEES:

- ASSOCIUM shall forward a monthly premium statement including all taxes payable to the Plan Sponsor the third week of each month.
- The premium amount shall be withdrawn the first week of the following month by ASSOCIUM via electronic funds transfer (EFT).
- Any erroneous amounts will be adjusted on the subsequent statement.

In connection with this ASSOCIUM Plan Sponsor Application for Group Insurance and the accompanying Schedule of Benefits the Plan Sponsor:

a) declares that to the best of his knowledge all statements, answers, and representations contained in the application are full, complete and true as of the date signed;

b) understands that coverage will not become effective until the application has been accepted and approved by the insurers underwriting the ASSOCIUM master group contracts issued to ASSOCIUM Benefits., and once accepted, the application will form part of the master group contracts;

c) agrees that a deposit equal to the one month's premium will be payable to ASSOCIUM Benefits has been submitted with the application and will be applied as a payment towards the first monthly premium once coverage is approved;

d) acknowledges that ASSOCIUM Benefits is the plan administrator in all matters pertaining to monthly premium billings, premium payments, employee enrolment, group records, employee records, insurer reports, and client service;

e) acknowledges that ASSOCIUM Benefits is the Agent of Record and authorizes them to perform their duties on our behalf and receive all fees and commissions. I further acknowledge that I can review the complete disclosure statement as well as privacy statement online at www.Associum.com;

f) acknowledges that the person or firm advising me on the purchase and subsequent renewals of this group contract has advised me that they will receive a commission from the Group Benefits Provider, that the commission is an element of the rate calculation, and that any future increase in the schedule of that commission will require my written approval and of any conflicts of interest they may have with respect to this transaction.

g) understands that all forms, documents, group records, employee records, reports and other materials used in the administration of this plan, whether in paper or electronic form, are the property of insurers. It is a requirement of each of the insurers underwriting the Group Policy that all such administrative materials be retained by ASSOCIUM Benefits, on their behalf, in a manner and for the time periods prescribed by these insurers. Data, including claims data, will be provided to the insurers for the purpose of administering and managing the plan as required ;

h) agrees to abide by and be subject to all the terms, conditions, rules, regulations, policy particulars, definitions and other provisions as set out in the ASSOCIUM Benefits master group contracts issued to ASSOCIUM Benefits, including any additions or amendments thereto, copies of which are available to view at the offices of ASSOCIUM Benefits during normal business hours;

i) acknowledges that certain contractual and administrative conditions exist with respect to employer eligibility, employee eligibility, employee participation, waiting periods, effective dates of coverage, evidence of insurability, pre-existing conditions and eligibility for late applicants, and agree s to accept and adhere to these conditions; and

j) agrees to save harmless and indemnify ASSOCIUM Benefits, its shareholders, directors, officers, agents and employees and their respective heirs, executors or assigns, from and against all claims, demands, losses, damages, costs, charges and expenses to which they may be exposed as a direct or indirect, complete or partial consequence of the Employer, any employee of the Employer or any insurance agent acting on behalf of the Employer having supplied inaccurate, incomplete, or false information, or for failing to observe the terms of the ASSOCIUM Benefits master group contracts issued to ASSOCIUM Benefits.

k) Understands that the quoted payment method is via EFT. For payment by cheque, a processing fee of $20.00/ month will be added to your bill.

Authorized Signature of Employer	Date	Witness Signature	Date

11. Pre-Authorized Debit (PAD) Plan Agreement

A.C. Johnson & Associates Inc O/A ASSOCIUM O/A GAIN

Please complete the Pre-Authorized Debit (PAD) Plan Agreement below and attach a void cheque.

I/we authorize A.C Johnson & Associates Inc and the financial institution designated (or any other financial institution I/we may authorize at any time) to begin deductions as per my/our instructions for monthly regular recurring payments and/or one-time payments from time to time, for payment of all charges arising under my/our A.C Johnson & Associates account(s). Regular monthly payments for the full amount of services provided will be debited to my/our specific account on the last business day of each month. A.C Johnson & Associates Inc will provide ten (10) days written notice of the amount of each regular debit. A.C Johnson & Associates will obtain my/our authorization for any other on-time or sporadic debits.

This authority is to remain in effect until A.C Johnson & Associates Inc has received written notification from me/us of its change or termination. This notification must be received at least ten (10) business days before the next debit is scheduled at the address provided below. 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 cdnpay.ca.

A.C Johnson & Associates Inc may not assign this authorization, whether directly or indirectly, by operation of law, change of control or otherwise, without providing at least ten (10) days prior written notice to me/us.

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 PAD that is not authorized or is not consistent with this PAD agreement. To obtain a form for a Reimbursement Claim, or for more information on my/our recourse rights, I/we may contact my/our financial institution or visit cdnpay.ca.

Type of Service: ☐ Business ☐ Personal

Payor's Legal Name: _____

Address: _____

City/Town _____ Province _____ Postal Code _____

Phone Number: _____ Extension: _____

Financial Institution (FI): _____

Branch Address: _____

City/Town _____ Province _____ Postal Code _____

FI Bank Number _____ FI Transit Number _____ FI Account Number _____

_____

Authorized Signing Officer Date

_____

Name and Title of Signing Officer

Head Office Use Only:

Client #:	
Received Date :	
Posted Date:	
Signature :	

12. Schedule of Benefits

Attached copy of Proposal.