

APPLICATION FOR: GROUP INSURANCE
(complete in full)

APPLICANT INFORMATION

Applicant (print full **legal** name of business as it should appear in the policy):

Mailing address: (in full – Street, City, Province, Postal Code):

Business location: (Street, City, Province, Postal Code):

Legal Status: Corporation Partnership Sole proprietorship Trustee
 Union Association Other

Nature of business (goods or services provided):

How long has business been in operation?

Union Yes No If the Union is the Policyholder, please attach a copy of the union contract or pages referring to group benefits.

Contact person name: _____ Title: _____

Phone #: _____ Fax #: _____

Email address: _____ Can we communicate with you via email? Yes No

Print full legal names and addresses of any subsidiary or affiliated companies which are to be covered.

Subsidiary	Affiliated	Full legal names (as they should appear in the policy) and addresses of the companies
<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	

Effective date requested: 1st day of _____, **20**_____
(month) (year)

To avoid a period without coverage, 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.

CURRENT COVERAGE

1. Will the insurance applied for replace similar insurance? Yes No If YES, complete the following as required for pre-existing condition information purposes.

Benefit	Prior Carrier	Effective date of Prior Coverage
Life		
AD&D		
Optional Life		
Optional AD&D		
Dependent Life		
Weekly Indemnity		
Long Term Disability		
Extended Health Care		
Dental Care		

2. Is this group currently part of an association plan? Yes No If YES, name of assoc. _____

3. Copy of most recent billing (for grandfathering purposes) is attached? Yes No

PREMIUM CONTRIBUTIONS

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

Life/AD&D	%	Long Term Disability	%
Dependent Life	%	Extended Health Care	%
Weekly Indemnity	%	Dental Care	%

ELIGIBILITY

Classes	# Employed	# Eligible	# Enrolling
<input type="checkbox"/> Permanent full-time			
<input type="checkbox"/> Permanent part-time			
<input type="checkbox"/> Union			
<input type="checkbox"/> Non-Union			
<input type="checkbox"/> Seasonal			
<input type="checkbox"/> Contract			
<input type="checkbox"/> Job Sharing Employees			
<input type="checkbox"/> Extended Shift Hours			
<input type="checkbox"/> Temporary Employees			
<input type="checkbox"/> Independent Contractors			
<input type="checkbox"/> Partners, Directors, Trustees and Shareholders			
<input type="checkbox"/> Retirees			
<input type="checkbox"/> Other:			

Full-time individuals must work _____ hours per week.

Part-time individuals must work _____ hours per week.

Other individuals must work _____ (example: hour bank employees-indicate hour bank requirements for benefits)

New individuals under age 65 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 individuals 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.

ADDITIONAL INFORMATION

If **YES** is responded to any of the following questions, please provide details below or attach a separate page.

1. a) Are any individuals currently receiving disability benefits under a group plan, WCB or any other source? Yes No

- b) Has the current insurer waived the life insurance premium for these individuals? Yes No

2. Any individuals currently absent from work due to sickness or injury? Yes No

3. Are any Owners, Partners, Shareholders or other individuals not actively working at the business on a consistent basis? Yes No

4. Please state name(s) of owner(s):

Are the owners being paid a salary? Yes No If "No" please provide details on how income is paid.

5. Please indicate the number of individuals enrolling by location:

Location	Number Enrolling	Location	Number Enrolling
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Please state class and/or names for the following:

6. Any individuals NOT covered by Worker's Compensation.

7. Any individuals NOT covered by Employment Insurance.

8. Any individuals related to one another (ie. spouse, parent, child, sibling). State relationship.

9. Any individuals paid in full or in part by commissions.

10. Any individuals NOT being paid a salary or commissions. If yes, provide details on how income is paid.

11. Are Independent contractors covered under this plan? Yes No If "Yes" please provide details on how income is paid.

Are Independent Contractors employed by the employer on a regular full time basis? Yes No

What are the minimum number of hours worked weekly?

What is the length of the employment contract?

Is there an automatic annual renewal of the individuals' contract with the employer? Yes No

12. Are any employees laid off on a seasonal basis with a fixed recall date? Yes No

If yes, what is the maximum duration of the seasonal lay-off?

13. Are any owners, partners, shareholders or any other individuals not contributing to CPP? Yes No

If yes please list.

ADMINISTRATION

3. **Third party administrator:**

Full Name: **Matrix Benefit Services Ltd.**

Address: **700 Finley Avenue, Unit 5 Ajax, Ontario L1S 3Z2**

Phone Number: **905-426-8850**

Fax Number: **905-426-9844**

www.matrixontario.com

PLAN PROFILE

Coverages and sold rates:

Please provide a copy of the sold rates and plan design. (schedule of benefits)

APPLICANT'S DECLARATION

The applicant hereby declares that, to the best of the applicant'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) such statements and answers will be relied on by Co-operators Life Insurance Company, if it issues a group policy; (2) the insurance under the group policy shall become effective in accordance with and subject to the terms of the policy issued to the applicant; (3) in no case shall coverage become effective until this application has been approved in writing by Co-operators Life Insurance Company; and (4) Co-operators Life Insurance Company will not be liable to the applicant or to any of the applicant's employees or any other persons proposed to be covered under this application until it has been approved 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.

In the case of apparent errors and omissions discovered by Co-operators Life Insurance Company in this Application for Group Insurance, Co-operators Life Insurance Company is hereby authorized to amend this Application for Group Insurance by noting the change(s) in the section below. Acceptance of a copy of this Application for Group Insurance so amended shall constitute a ratification of such corrections or amendments.

Dated at _____ this _____ day of _____

By _____ (Applicant's signature)

Title _____

(Applicant's Printed Name)

PRODUCER'S DECLARATION

Agent/Broker Name: _____

Address (in full – Street, City, Province, Postal Code): _____

Phone #: _____

Fax #: _____

E-mail Address: _____

SR4 Agent #: _____

Commission Schedule attached. _____

Yes

License attached:

License already submitted:

Note: A renewed license must be submitted to Co-operators upon expiry.

Comments: _____

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: _____