



New Group Application



General Information

Agent Name: _____ Office: _____

Client Information

Company Name: _____

Nature of Business: _____

Address: _____ City: _____ Province: _____ Postal Code: _____

Telephone: _____ Fax: _____

Name of Plan Administrator: _____ Title: _____

Email Address: _____

Nature of Business: _____ In Business Since: _____

Association Member Yes No If YES, Association Name: _____

Present Carrier: _____ With Present Carrier Since: _____

Current number of Employees: _____ Full Time: _____ Part Time: _____

Employer must withhold tax and issue a T4 slip for all eligible employees

Full time employees are considered as those working a minimum of 24 hours/week

Are any employees currently hospital confined or off work due to disability? Yes No

If YES, please explain: _____

Employer Premium Contribution: _____ % Employee Premium Contribution: _____ %

If the Employer is paying the entire cost of the plan, 100% of all employees must participate

If the Employees are paying a portion of the premium, 85% of all employees must participate

Monthly Premium Payment Options EFT Credit Card

Effective Date of Group Benefits: _____

Reimbursement Benefits

Healthcare

Choose pre-defined Health Plan (See BeneShield Guide)

A B C D and/or customize any benefit option below

Medical Supplies and Services

Semi-Private Hospital, Ambulance and Out of Country expenses included in all Healthcare options, payable at 100%, no deductible

Deductible (also applies to prescription drug expenses)

Nil \$25/\$25 \$25/\$50 \$50/\$50 \$50/\$100

Coinsurance: 50% 60% 70% 80% 90% 100%

Paramedical Maximum: \$300 \$400 \$500 \$750 Other \$ _____

Paramedical Per Visit Maximum: \$20 \$25 \$30 \$35 \$40

Drugs

Dispensing Fee Maximum: \$6.00 \$7.00 \$8.00 \$9.00 Unlimited

Maximum: \$1,500 \$5,000 \$10,000 Unlimited

Vaccines: Included Not Included

Lifestyle Drugs (fertility, anti-smoking, anti-obesity and treatment of sexual dysfunction): Included Not Included

Vision

Included Not Included

Maximum \$200 \$250 \$300 Other \$ _____

Dentalcare

Choose pre-defined Dental Plan (See BeneShield Guide)

A B C D and/or customize any benefit option below

Deductible: Nil \$25/\$25 \$25/\$50 \$50/\$50 \$50/\$100

Routine Coinsurance: 50% 60% 70% 80% 90% 100%

Routine Maximum: \$750 \$1,000 \$1,500

Scaling Time Units: 6 units 8 units 10 units 12 units 14 units

Recall Exams: 1 every 6 months 1 every 9 months 1 every 12 months

Major Coinsurance (when 5 or more plan members have this coverage): 50% 60% 70% 80%

Combined Routine and Major Maximum: \$750 \$1,000 \$1,500 \$2,000 \$2,500

Orthodontic Coinsurance (when 10 or more plan members have this coverage): 50% 60%

Ortho Maximum: \$1,000 \$1,500 \$2,000 \$2,500

Notes:



Employee Waiting Period

2 months for new employees 3 months for new employees 6 months for new employees other _____

Class Descriptions

If more than one benefit class of employees, describe each class of employees who will be eligible for benefits

Class A _____ Class B _____

Insured Benefits

Match benefit options to quote proposal dated: _____

Life and Accidental Death & Dismemberment (mandatory)

Flat Benefit Amount	Or Salary-Based Amounts	Maximum (up to \$500,000)
<input type="checkbox"/> Class A \$ _____	<input type="checkbox"/> Class A _____ x annual salary	<input type="checkbox"/> Class A _____
<input type="checkbox"/> Class B \$ _____	<input type="checkbox"/> Class B _____ x annual salary	<input type="checkbox"/> Class B _____

Dependent Life (mandatory)

\$5,000 spouse; \$2,500 each dependent child \$20,000 spouse; \$10,000 each dependent child
 \$10,000 spouse; \$5,000 each dependent child \$25,000 spouse; \$12,500 each dependent child
 \$15,000 spouse; \$7,500 each dependent child

Short Term Disability

Coverage	Options	Duration	Maximum
<input type="checkbox"/> 60% of salary	<input type="checkbox"/> 1st day hospital	<input type="checkbox"/> 17 weeks	\$ _____ Select maximum up to \$750
<input type="checkbox"/> 66 2/3% of salary	and/or	<input type="checkbox"/> 26 weeks	
	<input type="checkbox"/> 4th day illness or <input type="checkbox"/> 8th day illness		

Long Term Disability

Options	Duration	Elimination Period	Maximum
<input type="checkbox"/> 60% of monthly salary	<input type="checkbox"/> 5 years	<input type="checkbox"/> 119 days	\$ _____
<input type="checkbox"/> 66 2/3% of monthly salary	<input type="checkbox"/> 10 years	<input type="checkbox"/> 180 days	3 – 14 lives, up to \$5,500
	<input type="checkbox"/> to age 65		15+ lives, up to \$7,000

Cost of Living Adjustment (COLA) Option

not included 1% 2% 3%

For the above benefits, all eligible employees must participate for groups with 10 lives or less. When 10 or more lives, 85% of all eligible employees must participate.

Critical Illness

Minimum \$10,000 to a Maximum \$100,000

Employee only

Employee

Spouse

Employee and Spouse

Class A _____ Class A _____

Class B _____ Class B _____

Employee Assistance Program (EAP)

Health Care Spending Account (HCSA)

Annual Lump Sum Class A \$ _____ Class B \$ _____

Authorizing Signature

I hereby acknowledge and certify that I have read this application and the information provided is true and accurate

Company Legal Name: _____

Authorizing Signature: _____ Title: _____

Date: _____

Agent Signature: _____ Date: _____

Submit completed application to: Western Life Assurance Co.
P.O. Box 3300, Winnipeg, MB, R3C 5S2
Fax: 1-877-647-5433
Email: group.services@westernlife.com

Please ensure the attached payment option form is completed in full and submitted with this application

Payment Option Form

Please select Option 1 or 2, complete Payor Information carefully read the authorization, sign and date the bottom of this page.

Group Name: _____

OPTION 1 - PRE-AUTHORIZED PAYMENT PLAN - ATTACH SAMPLE CHEQUE MARKED 'VOID'

Name of Bank Account Holder: _____ Type of Service: Personal Business

OPTION 2 - CREDIT CARD

Card Type: MASTERCARD VISA

Card Number: _____ Expiry Date: _____

Name, as it appears on the Credit Card: _____

Payor Information

Bank Account Holder/Credit Cardholder Address: _____

City/Town, Province: _____ Postal Code: _____ Phone: _____

Authorization and Signature

Option 1:

Western Life Assurance Company is requested and authorized to draw cheques under its Pre-Authorized Payment Plan on the Account and Financial Institution designated by me. I further authorize such institution and any of its branches to deal with such transfers as though they were signed by me.

- I also agree to furnish Western Life Assurance Company with a voided blank cheque now and at any future time, as required, to assure the accurate imprinting of bank information on my Pre-Authorized transfers.
- I may revoke my authorization at any time, subject to providing notice of 30 days notice. To obtain a sample cancellation form, or for more information on my right to cancel a PAD Agreement, I may contact my financial institution or visit www.cdnpay.ca
- Every effort will be taken to meet the same date every month, however this date could change for a given month.
- Western Life is not required to provide notification before the initial premium is debited.
- I have certain recourse rights if any debit does not comply with this agreement. For example, I have the right to receive reimbursement for any debit that is not authorized or is not consistent with this pre-authorized debit (PAD) Agreement. To obtain more information on my recourse rights, I may contact my financial institution or visit www.cdnpay.ca

Option 2:

Western Life Assurance Company is requested and authorized to charge the Credit Card. I agree to furnish Western Life Assurance Company with the updated Credit Card date as required. This authorization extends to any replacement cards I may receive and will remain in effect until I cancel it.

Regular recurring payments arising under our Group Insurance account(s) for the full amount billed, will be debited to the specified account on the 8th of the month or charged to the specified credit card on the 1st day of each month.

In the event of an unsuccessful payment, a \$35.00 fee will apply.

I agree that this authorization in no way affects the terms or conditions of the policy.

The authorization shall continue in force so long as said group coverage shall qualify for premium payments under this plan or until this authorization is revoked. Either party to this agreement may terminate this authorization by written notice mailed to the other party at his address of record.

Signature of Bank Account Holder/Credit Cardholder: _____

Dated: _____

MM/DD/YYYY



Form Number WLAG 2100-08/11

Western Life Assurance Company
Administrative Office: 717 Portage Ave, 4th Flr, Winnipeg MB R3G 0M8
Mailing Address: P.O. Box 3300, Winnipeg MB R3C 5S2
Telephone 204-784-6900 or 888-647-LIFE (5433) Fax 204-783-6913

