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ICBA BENEFITS

Employer Application
Entrepreneur Plan

For ICBA Benefits use:
Client code: _____

Effective date (mm/dd/yyyy): _____

Company Information

Organization/Company		Proposed Effective Date (mm/yyyy)	
Company Address	City	Province	Postal Code
Company Email Address		Phone No.	
Contact Person		Title	

Benefits Summary *(See brochure or plan booklet for more details)*

Note: The options you select are locked in for two years, and can only be changed on January 1st.

Benefit	Underwriter and Policy #	Monthly Cost – Effective January 1, 2021 (Rates are subject to change every January 1st)
LIFE INSURANCE • $25,000 • Reduces by 50% at age 65 • Terminates at age 75	Great-West Life Policy #350300	Under age 65: $10.30 Age 65-75: $5.15
ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) • $25,000 • Reduces by 50% at age 65 • Terminates at age 75	Great-West Life Policy #350300	Under age 65: $0.75 Age 65-75: $0.38
DEPENDENT LIFE INSURANCE • $10,000 Spouse / $5,000 Child • Terminates at employee age 75	Great-West Life Policy #350300	$5.38
LONG TERM DISABILITY • 66.67% of monthly salary up to $3,000 • Elimination period: 120 days • Benefits paid for up to 5 years • Termination age – 65	Great-West Life Policy #350301	$2.953 for every $100 of monthly benefit **Calculation Example:** Monthly salary: $3,600 Monthly benefit: $3,600 * 66.67 = $2,400 Monthly cost: $2,400/$100 * $2.953 = $70.87
		Select Option:
EXTENDED HEALTH CARE (EHC) All options cover: • 100% Travel insurance • 100% for vision care up to $200 every 24 months for adults and $200 every 12 months for children • $300 every 12 months for Foot Orthotics • Professional services (e.g. chiropractor, physiotherapist, massage therapy) - $300 per year per practitioner type • Medical Aids & Equipment • Up to $5,000/year for drugs, including vaccines • Brand name drugs paid at generic equivalent Coverage terminates on 75th birthday	Great-West Life Policy #350300	○ OPTION 1 Single - $63.19; Family - $163.79 • $250 annual deductible; Nil deductible on drugs • 100% for Travel and Vision • 80% for drugs purchased at Costco* • 70% for all other covered expenses ○ OPTION 2 Single - $90.43; Family - $273.83 • $100 annual deductible, Nil deductible on drugs • 100% for Travel and Vision • 90% for drugs purchased at Costco* • 80% for all other covered expenses ○ OPTION 3 Single - $149.98; Family - $449.19 • No deductible • 100% for Travel and Vision • 100% for drugs purchased at Costco*; otherwise 90% for drugs • 90% for all other covered expenses *Costco membership is not required for pharmacy purchases.

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DENTAL All options include: • 2 recall visits and up to 10 units of scaling per year • Coverage terminates on 75th birthday	Great-West Life Policy #350300	○ OPTION 1 Single - $61.48; Family - $144.39 • 80% Basic up to $1,500/year ○ OPTION 2 Single - $84.16; Family - $180.98 • 80% Basic and 50% Major up to $1,500 year • 50% Orthodontia for children, up to $2,000 lifetime. Treatment must begin between ages 6 and 18. ○ OPTION 3 Single - $101.54; Family - $223.21 • 100% Basic and 50% Major up to $1,500 year • 50% Orthodontia for children, up to $2,000 lifetime. Treatment must begin between ages 6 and 18.
SHORT TERM DISABILITY (STD) – OPTIONAL • 66.67% of salary up to to the current EI maximum • Benefit pays on 1st day of hospitalization, 8th day of illness/injury for up to 17 weeks	Great-West Life Policy #350301	○ DO NOT INCLUDE SHORT TERM DISABILITY ○ INCLUDE SHORT TERM DISABILITY $0.83 for every $10 of weekly benefit **Calculation Example:** Monthly salary: $3,000 (Annual: $36,000) Weekly benefit: $36,000/52 * 66.67 = $462 Monthly cost: $462/$10 * $0.83 = $38.35
ADMINISTRATION FEE:		$10.00

OPTIONAL LIFE INSURANCE

Available in increments of $10,000 to a maximum of $250,000.
Evidence of insurability is required. Find application forms at icbabenefits.ca/Entrepreneur

Monthly rates for every $10,000 of coverage:

Age	Male, Non-Smoker	Female, Non-Smoker	Male, Smoker	Female, Smoker
Up to 34	$0.690	$0.575	$1.150	$0.805
35-39	$0.805	$0.690	$1.495	$1.150
40-44	$1.150	$1.035	$2.415	$1.840
45-49	$2.185	$1.840	$4.485	$3.105
50-54	$3.795	$3.105	$7.475	$5.060
55-59	$7.015	$4.945	$12.880	$7.705
60-64	$9.890	$6.555	$17.365	$9.660

OPTIONAL ACCIDENTAL DEATH & DISMEMBERMENT (AD&D)

Available in increments of $10,000 to a maximum of $250,000. The amount you select is known as the Principal Sum.
Find application forms at icbabenefits.ca/Entrepreneur.

Two plans are available:

Plan 1	Cost per $1,000 Principal Sum
Employee Plan	$0.0824

Plan 2	Cost per $1,000 Principal Sum
Family Plan	$0.1118

- Employee is insured for the Principal Sum
- Spouse is insured for 40% of the Principal Sum, 50% if there are no covered children.
- Children are insured for 5% of the Principal Sum, 10% if there is no Spouse.

Employer Application
Entrepreneur Plan

Eligible Employees

All employees working 24 hours per week or more on a regular basis are required to join the plan on their date of hire. Applications must be received within 31 days of their date of hire, otherwise evidence of insurability will be required and their application may be declined. Contract employees and employees employed only on a seasonal basis are not eligible.

Actively at Work requirement – Actively at Work means the employee is performing all the duties normally associated with their job. Current employees must be actively at work on the effective date of this plan in order to be eligible for coverage. If you have employee(s) who are not

Actively at Work, do not include their application until they return to work. An employee who is on vacation or a regular day off but is otherwise mentally and physically capable of performing all the duties normally associated with their job is considered Actively at Work.

Cost Sharing

The employer must contribute at least 50% to the cost of the plan. Exception: Optional Life and Optional AD&D are 100% employee-paid. Please indicate your company's cost-sharing for this plan:

- ○ 50/50 Split, with the Employer's portion used first for EHC and Dental benefits, and the Employee's portion used first for STD, LTD, Life and AD&D benefits
- ○ As indicated in following table

Benefit	Employer Share	Employee Share
Life, AD&D and Dependent Life	%	%
Short Term Disability	%	%
Long Term Disability	%	%
EHC	%	%
Dental	%	%

Authorization

We hereby apply for benefits under the Entrepreneur Plan, and agree to the terms and conditions set forth in Great-West Life policies 350300, 350301 and 350302.

We understand that premiums are due on the first of every month, and agree to pay them in full by pre-authorized debit on the first of every month.

We understand that the benefit options we have selected are locked in for a minimum period of 2 years, and can only be changed on January 1st.

We confirm that the employees whose applications are submitted with this Employer Application are Actively at Work.

We understand that we can terminate this plan at any time with 30 days written notice to ICBA Benefits.

Authorized Signature Name (print)	
Signature	Date Signed (mm/dd/yyyy)

Entrepreneur Plan
Pre-Authorized Debit Authorization
Pre-Authorized Debit (PAD) Agreement

Authorization	Note: References in the PAD agreement to "this PAD agreement" include later amendments to it. Reference in this PAD agreement to "we" and "our" refers to the policyholder (payor). We authorize ICBA Benefit Services Ltd. (ICBA Benefits) and the financial institution named above (or any other financial institution we may authorize at any time) to withdraw from our account any payments that we have agreed to make under the policy listed above, and/or as otherwise specified to us made in the PAD agreement as though we had personally signed a cheque. We understand that changes to the policy, including as applicable, to premium amounts or to the method or required amount of payment (including changes requested to this PAD agreement) or termination and recommencement of automatic payments under this PAD agreement may increase or decrease the amount withdrawn or to be withdrawn from our account. Accordingly, we authorize such increases or decreases, waiving any pre-notification requirement with respect to them. We agree that a photocopy or electronic copy of the PAD agreement will be as valid as the original.
Signatures	We certify that all persons whose signatures are required to authorize this PAD agreement have signed below, including any required joint account holder.
Account changes	We will notify ICBA Benefits if our financial institution, transit (branch) or account number changes. To continue withdrawals without interruption, notice of any change is required 14 days before the change effective date. ICBA Benefits may, but is not obligated to, rely on verbal instructions from us to amend this authorization.
Confirming withdrawals	We agree to regularly review our account information and if we question or disagree with the amount withdrawn or any account changes, we will notify ICBA Benefits in writing within 10 days of the withdrawal or account changes; otherwise, we agree that the withdrawal or account changes will be considered to have been properly made.
Non-sufficient funds (NSF) information	If funds in our account are not sufficient to cover the total amount due ("due" as an amount owing, or an amount otherwise specified to be withdrawn under this PAD agreement), we authorize ICBA Benefits to immediately make a second attempt to withdraw the amount due (which may be greater than the amount due at the first attempt). We understand that we are responsible for any NSF charge(s). We understand that our claims payments will be suspended if our payment is NSF, and our policy will be terminated if payments are NSF for two consecutive months' premiums.
Asignment	We hereby waive any requirement of prior written notice to us by ICBA Benefits of the assignment of ICBA Benefits of this PAD agreement.
Cancellation	This PAD agreement may be cancelled if any withdrawal is not permitted or is reversed by the financial institution, or upon 30 days written notice given by us to ICBA Benefits, or by ICBA Benefits to us.
Recourse	We have certain recourse rights if any debit does not comply with this PAD agreement. For example, 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 our recourse rights, we can contact our financial institution or visit www.cdnpay.ca.

Void cheque attached Direct deposit form from financial institution attached Bank account details provided below

Name of Institution:	Branch Address:	
Institution No.	Transit (branch) No.	Account No.

If this is a joint account, the following section must be completed by both accountholders.

1st Accountholder Name:	2nd Accountholder Name (if applicable):
Signature	Signature
Date signed (mm/dd/yyyy):	Date signed (mm/dd/yyyy):

Submit this Authorization, along with a void cheque or direct deposit form, and your Application to ICBA Benefits at 700-4730 Kingsway, Burnaby, BC, V5H 0C6.

Employee Enrolment Form
Entrepreneur Plan
Great-West Life Policy 350300 / 350301

Organization/Company	Client Code	Employee Date of Hire

Section 1 - Employee Information

Name (first, last)	Date of birth (mm/dd/yyyy)	Gender ○ Male ○ Female ○ X	ID No. (will be assigned by ICBA Benefits)
Occupation	Salary $ Per: ○ Hour ○ Month ○ Year		Hours worked per week:
Address	City	Province	Postal code
Email			Date Signed (mm/dd/yyyy)

Section 2 - Dependent Information

Complete this section if you have a spouse/eligible children, even if you are declining EHC or Dental coverage for them. You are eligible for Dependent Life Insurance if dependents are listed in this section.

☐ More than 5 children, attach list.

	Last Name	First Name	Date of Birth (mm/dd/yyyy)	Gender	If child is over 21:
Spouse				○ Male ○ Female ○ X	N/A
Child 1				○ Male ○ Female ○ X	☐ Full-time Student ☐ Disabled [1]
Child 2				○ Male ○ Female ○ X	☐ Full-time Student ☐ Disabled
Child 3				○ Male ○ Female ○ X	☐ Full-time Student ☐ Disabled
Child 4				○ Male ○ Female ○ X	☐ Full-time Student ☐ Disabled
Child 5				○ Male ○ Female ○ X	☐ Full-time Student ☐ Disabled

Section 3 - Complete this section only if you are DECLINING coverage for your eligible dependents - only allowed if they are covered by another plan. Note: you cannot waive coverage for yourself under this plan.

I understand the plan of group benefits offered, and I am declining coverage for my eligible spouse and children in:

☐ EHC ☐ Dental

Name of Insurance Company you dependents' plan is with: _____

Please read carefully before signing this section.

I confirm that the person(s) I am waiving coverage for has/have coverage under another plan for these benefits. I understand that my eligible dependents may join this plan at a later date if I/they apply within 31 days of the other plan cancelling; otherwise they will be required to provide evidence of good health, and their application may be declined.

Employee Signature	Date signed (mm/dd/yyyy):

1. Attach completed Great-West Life Application for Over-Age Dependent Coverage form, available at icbabenefits.ca/Entrepreneur

Employee Enrolment Form
Entrepreneur Plan
Great-West Life Policy 350300 / 350301

Section 4 - Beneficiary information for Life and Accidental Death Insurance

Primary Beneficiary(ies) ☐ To designate more than 4 primary beneficiaries, complete Beneficiary Designation form

	Name (first, middle initial, last)	Relationship to you	Type [1]	Percentage [2]
1			○ Revocable ○ Irrevocable	
2			○ Revocable ○ Irrevocable	
3			○ Revocable ○ Irrevocable	
4			○ Revocable ○ Irrevocable	

Trustee (Complete if any beneficiary is under the age of majority.) Not applicable in Quebec.

I appoint (full legal name) _____
as Trustee to receive any amount due to any beneficiary under the age of majority.

Contingent Beneficiary (Optional)

The person(s) who will receive insurance proceeds should none of your primary beneficiaries survive you. Should you assign more than one contingent beneficiary, proceeds will be split evenly among them.

	Name (first, middle initial, last)	Relationship to you	Type [1]	Percentage [2]
1			○ Revocable ○ Irrevocable	
2			○ Revocable ○ Irrevocable	

Section 5 - Employee Declaration and Authorization

Protecting your personal information

ICBA Benefits is committed to protecting the privacy, confidentiality, accuracy and security of your personal information. When you apply for insurance coverage, we establish a confidential file and collect, use and disclose your personal information for the purposes of issuing and administering your insurance. ICBA Benefits is compliant with Canadian and provincial legislation. Please see our website for our complete Privacy Policy.

Declaration and authorization

I hereby apply for coverage under this policy, and accept its terms and conditions. I authorize the necessary contributions to be made through payroll deductions, if applicable. I authorize my employer and ICBA Benefits, the insurance company and its reinsurers, any healthcare provider, administrators of government benefits or other benefits programs to give, receive and share any personal information regarding my eligibility for coverage to administer the plan, or those of my dependents, if applicable.

I certify that I am covered, and my spouse and children (if applying for coverage) are covered by a provincial medical plan, e.g. Medical Services Plan of BC.

I certify that all of the information I have provided on this form is true, correct and complete to the best of my knowledge.

Signature	Date signed (mm/dd/yyyy):

1. If you designate a beneficiary as “irrevocable”, you cannot change your beneficiary without that person’s written permission. Children cannot give permission until they reach the age of majority.

2. Percentages must total 100% or the designation will be invalid. If percentages left blank, proceeds will be divided equally among the primary beneficiaries.