



## 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, 2022 (Rates are subject to change every January 1st)
<b>LIFE INSURANCE</b> <ul style="list-style-type: none"> <li>\$25,000</li> <li>Reduces by 50% at age 65</li> <li>Terminates at age 75</li> </ul>	Canada Life Policy #350300	\$10.30
<b>ACCIDENTAL DEATH &amp; DISMEMBERMENT (AD&amp;D)</b> <ul style="list-style-type: none"> <li>\$25,000</li> <li>Reduces by 50% at age 65</li> <li>Terminates at age 75</li> </ul>	Canada Life Policy #350300	\$0.75
<b>DEPENDENT LIFE INSURANCE</b> <ul style="list-style-type: none"> <li>\$10,000 Spouse / \$5,000 Child</li> <li>Terminates at employee age 75</li> </ul>	Canada Life Policy #350300	\$5.38
<b>LONG TERM DISABILITY</b> <ul style="list-style-type: none"> <li>66.67% of monthly salary up to \$3,000</li> <li>Elimination period: 120 days</li> <li>Benefits paid for up to 5 years</li> <li>Terminates at age 65</li> </ul>	Canada Life Policy #350301	\$2.85 for every \$100 of monthly benefit  <div style="border: 1px solid blue; border-radius: 15px; padding: 10px; margin-top: 10px;"> <b>Calculation Example:</b>                      Monthly salary: \$3,600                      Monthly benefit: \$3,600 * 66.67% = \$2,400                      Monthly cost: \$2,400/\$100 * \$2.85 = \$68.43                 </div>
<b>Select Option:</b>		
<b>EXTENDED HEALTH CARE (EHC)</b> All options cover: <ul style="list-style-type: none"> <li>Brand name drugs paid at generic equivalent</li> <li>Up to \$5,000/year for drugs, including vaccines</li> <li>\$300/year per paramedical practitioner (e.g. chiropractor, physiotherapist, massage therapy)</li> <li>Medical Aids &amp; Equipment (e.g. \$300 every 12 months for Foot Orthotics)</li> <li>100% for vision care up to:                             <ul style="list-style-type: none"> <li>-\$200 every 24 months for adults and</li> <li>-\$200 every 12 months for dependent children</li> </ul> </li> <li>100% Travel insurance</li> <li>Terminates at age 75</li> </ul>	Canada Life Policy #350300	<input type="radio"/> <b>OPTION 1</b> Single - \$69.00; Family - \$178.84 <ul style="list-style-type: none"> <li>\$250 annual deductible</li> <li>70% coverage except travel insurance and vision care</li> <li>80% for drugs purchased within Canada Life's preferred pharmacy network</li> </ul> <input type="radio"/> <b>OPTION 2</b> Single - \$98.75; Family - \$298.99 <ul style="list-style-type: none"> <li>\$100 annual deductible</li> <li>80% coverage except travel insurance and vision care</li> <li>90% for drugs purchased within Canada Life's preferred pharmacy network</li> </ul> <input type="radio"/> <b>OPTION 3</b> Single - \$163.76; Family - \$490.47 <ul style="list-style-type: none"> <li>No deductible</li> <li>90% coverage except travel insurance and vision care</li> <li>100% for drugs purchased within Canada Life's preferred pharmacy network</li> </ul>



<p><b>DENTAL CARE</b> All options include:</p> <ul style="list-style-type: none"> <li>2 recall visits</li> <li>Up to 14 units of scaling/year</li> <li>Terminates at age 75</li> </ul>	<p>Canada Life Policy #350300</p>	<p><input type="radio"/> OPTION 1 Single - \$67.53; Family - \$158.58 •80% Basic up to \$1,500/year</p> <p><input type="radio"/> OPTION 2 Single - \$92.44; Family - \$198.78 •80% Basic and 50% Major up to \$1,500/year •50% Orthodontia, up to \$2,000/lifetime</p> <p><input type="radio"/> OPTION 3 Single - \$111.52; Family - \$245.15 •100% Basic and 50% Major up to \$1,500/year •50% Orthodontia, up to \$2,000/lifetime</p>
<p><b>SHORT TERM DISABILITY (STD) – OPTIONAL</b></p> <ul style="list-style-type: none"> <li>66.67% of salary up to to the current EI maximum</li> <li>Benefit pays on 1st day of hospitalization, 8th day of illness/injury for up to 17 weeks</li> <li>Terminates at age 75</li> </ul>	<p>Canada Life Policy #350301</p>	<p><input type="radio"/> DO NOT INCLUDE SHORT TERM DISABILITY</p> <p><input type="radio"/> INCLUDE SHORT TERM DISABILITY \$0.83 for every \$10 of weekly benefit</p> <div style="border: 1px solid blue; border-radius: 15px; padding: 10px; margin-top: 10px;"> <p><b>Calculation Example:</b>  Monthly salary: \$3,000 (Annual: \$36,000)  Weekly benefit: \$36,000/52 * 66.67% = \$462  Monthly cost: \$462/\$10 * \$0.83 = \$38.35</p> </div>
<p><b>ADMINISTRATION FEE:</b></p>		<p>\$10.00</p>

**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](http://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	\$0.588	\$0.471	\$1.059	\$0.706
35-39	\$0.706	\$0.588	\$1.412	\$1.176
40-44	\$1.059	\$1.059	\$2.353	\$1.647
45-49	\$2.118	\$1.882	\$4.353	\$3.059
50-54	\$3.765	\$3.059	\$7.647	\$5.059
55-59	\$6.941	\$4.941	\$12.941	\$7.647
60-64	\$10.118	\$6.588	\$17.765	\$9.882

**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](http://icbabenefits.ca/Entrepreneur).

Two plans are available:

Plan 1	Cost per \$1,000 Principal Sum
Employee Plan	\$0.082
Plan 2	Cost per \$1,000 Principal Sum
Family Plan	\$0.112
<ul style="list-style-type: none"> <li>Employee is insured for the Principal Sum</li> <li>Spouse is insured for 40% of the Principal Sum, 50% if there are no covered children.</li> <li>Children are insured for 5% of the Principal Sum, 10% if there is no Spouse.</li> </ul>	



## Employer Application Entrepreneur Plan

### Eligible Employees

The employee must be under age 65 at the effective date of the plan enrollment.

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

Indicate the plan's premium cost-sharing with employees. (Note: The employer must contribute at least 50% of overall cost.)

100% paid by employer

50% paid by Employer, split tax-effectively with Employee

Other (indicate below)

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 Canada 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)

Date Signed (mm/dd/yyyy)

Signature





**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.

**Assignment**

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](http://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):
Date signed (mm/dd/yyyy):	Date signed (mm/dd/yyyy):
Signature	Signature

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.

**ICBA Benefit Services Ltd. - #800 - 13761 96th Avenue, Surrey, BC V3V 0E8**



604.227.1109 TF: 1.888.298.7752 Ext 120



[TeamTeal@icbabenefits.ca](mailto:TeamTeal@icbabenefits.ca)



[icbabenefits.ca](http://icbabenefits.ca)



**Employee Enrolment Form  
Entrepreneur Plan  
Canada Life Policy 350300 / 350301**

Organization/Company	Client Code	Employee Date of Hire
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**Section 1 - Employee Information**

Name (first, last)	Date of birth (mm/dd/yyyy)	Gender <input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> X	ID No. (will be assigned by ICBA Benefits)
Occupation	Salary \$ Per: <input type="radio"/> Hour <input type="radio"/> Month <input type="radio"/> Year	Hours worked per week:	
Address	City	Province	Postal code
Email			Date Signed (mm/dd/yyyy)
Coverage selected <b>Health:</b> <input type="checkbox"/> Single <input type="checkbox"/> Family <b>Dental:</b> <input type="checkbox"/> Single <input type="checkbox"/> Family			

**Coordination of Benefits Information - complete to coordinate benefits with your spouse's plan, if applicable**

Insurance Company	Policy/Group No.	Type of coverage: <input type="checkbox"/> Health <input type="checkbox"/> Dental	Cardholder: My spouse <b>Other:</b>	Coverage Single    Family
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**Dependent Information – complete if you have a spouse/eligible children, even if you are waiving coverage for them, if applicable**

**Note:** If your child is disabled, additional information is required to approve coverage beyond the plan's age limits. Contact us for more information.  More than 5 children, attach list

	Last Name	First Name	Date of Birth (mm/dd/yyyy)	Gender (X denotes other/non-binary)	If over 21:
Spouse				Male <input type="checkbox"/> X Female <input type="checkbox"/>	n/a
Child				Male <input type="checkbox"/> X Female <input type="checkbox"/>	<input type="checkbox"/> Full-time Student <input type="checkbox"/> Disabled
Child				Male <input type="checkbox"/> X Female <input type="checkbox"/>	<input type="checkbox"/> Full-time Student <input type="checkbox"/> Disabled
Child				Male <input type="checkbox"/> X Female <input type="checkbox"/>	<input type="checkbox"/> Full-time Student <input type="checkbox"/> Disabled
Child				Male <input type="checkbox"/> X Female <input type="checkbox"/>	<input type="checkbox"/> Full-time Student <input type="checkbox"/> Disabled
Child				Male <input type="checkbox"/> X Female <input type="checkbox"/>	<input type="checkbox"/> Full-time Student <input type="checkbox"/> Disabled





**Employee Enrolment Form  
Entrepreneur Plan  
Canada Life Policy 350300 / 350301**

**Section 2 - Beneficiary information for Life and Accidental Death Insurance**

<b>Primary Beneficiary(ies)</b> <input type="checkbox"/> To designate more than 4 primary beneficiaries, complete Beneficiary Designation form				
	Name (first, middle initial, last)	Relationship to you	Type <sup>1</sup>	Percentage <sup>2</sup>
1			<input type="radio"/> Revocable <input type="radio"/> Irrevocable	
2			<input type="radio"/> Revocable <input type="radio"/> Irrevocable	
3			<input type="radio"/> Revocable <input type="radio"/> Irrevocable	
4			<input type="radio"/> Revocable <input type="radio"/> Irrevocable	
<p><b>Trustee</b> (Complete if any beneficiary is under the age of majority.) Not applicable in Quebec.</p> <p>I appoint (full legal name) _____ as Trustee to receive any amount due to any beneficiary under the age of majority.</p>				
<p><b>Contingent Beneficiary (Optional)</b></p> <p>The person(s) who will receive insurance proceeds should none of your primary beneficiaries survive you. Should you assign more than one con-tingent beneficiary, proceeds will be split evenly among them.</p>				
	Name (first, middle initial, last)	Relationship to you	Type <sup>1</sup>	Percentage <sup>2</sup>
1			<input type="radio"/> Revocable <input type="radio"/> Irrevocable	
2			<input type="radio"/> Revocable <input type="radio"/> Irrevocable	

**Section 3 - Employee Declaration and Authorization**

<p><b>Protecting your personal information</b></p> <p>ICBA Benefits is committed to protecting the privacy, confidentiality, accuracy and security of your personal information. Your personal information, and the personal information of your spouse and dependents, if applicable, will be collected and used by us to determine your eligibility for group benefits coverage, to administer the group benefits plan, to assess benefits and insurance claims and for other purposes described in our Privacy Policy, which is available at <a href="http://icbabenefits.ca">icbabenefits.ca</a>. Access to personal information is limited to authorized employees and contractors of ICBA Benefits who require it to perform their duties, to those persons that you have granted access (such as your spouse or employer) and to other persons authorized by law.</p> <p>Personal information may also be shared with third parties that help us administer the group benefits plan, such as insurance companies and their reinsurers, your employer, health services providers, administrators of government benefits or other benefits programs and our technology partners, including for the purposes of verifying eligibility for specific benefits or claims, processing payments and investigating or reporting suspected or apparent fraudulent or suspicious claims behaviour.</p> <p>For more information about our privacy practices and procedures, please see our Privacy Policy or contact our Privacy Officer at <a href="mailto:privacy@icbabenefits.ca">privacy@icbabenefits.ca</a>.</p>	
<p><b>Declaration and authorization</b></p> <p>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.</p> <p>I have read, understand and agree with the section above entitled "Protecting your personal information" and hereby consent to the collection, use and disclosure of my personal information as described in this form and ICBA Benefits' Privacy Policy. If I have provided the personal information of my spouse or any dependents, I hereby confirm that I am authorized to act on their behalf.</p> <p>I understand that I am responsible for the accuracy of all claims submitted on behalf of myself, my spouse and/or my dependents, and that my eligibility and/or entitlement to any or all benefits under the Plan may be suspended and/or revoked without notice in the event that I, my spouse or any dependents am found to have made fraudulent or repeated inaccurate claims under the plan. Further, I hereby authorize my employer to deduct from my payroll and remit to the plan any amounts paid to me as a result of fraudulent or inaccurate claims by myself, my spouse or my dependents.</p> <p>I certify that I am covered, and my spouse and dependents (if applying for coverage) are covered by a provincial medical plan, e.g. Medical Services Plan of BC.</p> <p>I certify that all of the information I have provided on this form is true, correct and complete to the best of my knowledge.</p>	
Date signed (mm/dd/yyyy):	Signature

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.



Employee Enrolment Form  
Entrepreneur Plan  
Canada Life Policy 350300 / 350301

## Instructions/Additional Information:

**Client Code** – Indicate either number as it appears on your monthly invoice.

**Contingent Beneficiary** – If all the primary beneficiaries should die before you, proceeds will be paid to a contingent beneficiary. Should there not be any surviving beneficiaries at the time of your death, the proceeds will be paid to your estate.

**Coordination of Benefits information** – This information is required to establish which plan is primary and which plan is secondary for Health and Dental claims.

**Date of employment** – Indicate the date the employee began working 20 hours per week on a regular basis, not including overtime. Usually, this will be the original date of hire; however if the employee was hired on a casual basis, or on a part-time basis working less than 20 hours per week on average, enter the date employment changed to 20 hours/week. If this is a reinstatement, enter the date of rehire.

**Dependent Information** – complete this section if you have a spouse/eligible children, even if you are waiving coverage for them. If you are waiving Health and Dental coverage for your spouse/children, we need to know who your dependants are for two reasons: (1) in the event we later receive an enrolment request for them, and (2) your plan may include Dependent Life insurance. If you have more than 5 children, attach list with required information for the additional child(ren).

**Do you have a spouse?** – Indicate Yes if you are legally married or living in a common-law relationship.

**Do you have dependent children?** – Indicate Yes if you have a child(ren) under age 21, or a full-time student age 21-25, or a disabled child over age 21. If your child is disabled, additional information is required to approve coverage beyond the plan's age limits. Contact us for more information.

**Evidence of Insurability Form** – Contact us for the form.

**Gender** – Please indicate the gender per your government issued ID. For non-binary, indicate "X". Note: the insurance company may require a gender of male or female for underwriting purposes.

**If over 21** - To be covered on your plan beyond age 21, a child must either meet Canada Revenue Agency's criteria for a full-time student, or be disabled. If your child is disabled, additional information is required to approve coverage beyond the plan's age limits. Contact us for more information.

Do not return this page to ICBA Benefits.



**Employee Enrolment Form  
Entrepreneur Plan  
Canada Life Policy 350300 / 350301**

**Late Application** – If we receive this application more than 31 days after the employee is first eligible for coverage, it is considered late and **evidence of insurability** in the form of a completed health questionnaire is required. The insurance company may decline to cover the applicant(s). If the application is approved, coverage will begin as applicable, and Dental coverage will be restricted for the first 12 months of coverage. Contact us for the required form. The completed form can be scanned and emailed to us, or mailed. For confidentiality purposes, we suggest that the employee submit the form to us directly, or provide to you in a sealed envelope for mailing to us.

**Other** – Examples of Other plans, i.e. where the cardholder is not your spouse, include coverage you have through another employer or retiree plan. Please note, not all insurance companies will accept waivers/applications related to other coverage that is not a spouse's plan. We will let you know if your application / waiver is not accepted by the insurance company.

**Reinstatement** – If the employee previously had coverage under the plan and coverage terminated more than 6 months from the date of rehire, the plan waiting period will be applied to the date of rehire (unless there is written indication that the the Plan Sponsor/Employer is waiving the waiting period). If the previous coverage terminated less than 6 months from the date of rehire, coverage starts on the date of rehire. Note, both situations are subject to **late application** rules.

**Trustee** - Designate a trustee for any beneficiary who is younger than the age of majority in your province.

**Type (Beneficiary Designation)** – If you designate a beneficiary as Irrevocable, you cannot change your beneficiary designation without that person's consent. Important note: If you designate a minor child as your Irrevocable beneficiary, the child cannot consent to a change in beneficiary until they reach the age of majority. If you designate your beneficiary as Revocable, you may change your beneficiary designation at any time without restriction.

Do not return this page to ICBA Benefits.